Determinants of Implementation of Evidence-Based Practice in Clinical Decision-Making among Nurses in Primary Health Care Facilities

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Abstract

Background. Healthcare workers and institutions often face a lack of evidence-based and cost-effective care, which, if addressed, could improve practice and outcomes.

Aim. To assess the determinants of implementation of evidence-based practice (EBP) in clinical decision-making (CDM) among nurses in primary health care facilities.

Methods. The study utilized a descriptive cross-sectional design involving 266 nurses from primary healthcare facilities in Ondo State. Data were collected through a structured questionnaire administered via the online survey platform Google Forms. Findings are presented in frequency and percentage tables, and inferential statistics were analyzed using Chi-square tests at a 5% level of statistical significance.

Results. Knowledge has been identified as a key determinant in the implementation of Evidence-Based Practice (EBP) in Chronic Disease Management (CDM) among nurses in primary healthcare facilities. The study revealed that 73.7% of respondents demonstrated a strong knowledge of EBP in CDM, with the highest levels reported among ward managers. Additionally, access to EBP resources and consistent support from employers were major factors influencing successful EBP implementation, with 86% of respondents affirming the importance of these supports. Regarding implementation levels, 53.4% of respondents reported high implementation of EBP in CDM, while the remaining 46.6% indicated low implementation.

Conclusions. The study concluded that while nurses generally possessed good knowledge of Evidence-Based Practice, the highest levels of expertise were observed among ward managers. Key barriers to Evidence-Based Practice implementation in Chronic Disease Management were also identified, including limited network accessibility and inconsistent electricity supply.

Keywords: determinants; implementation; evidence-based practice; clinical decision-making; nurses

1. INTRODUCTION

Healthcare providers and institutions frequently encounter significant challenges in delivering

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evidence-based, high-quality, and cost-effective care, which, if systematically addressed, could markedly enhance clinical practices and patient outcomes (Bashar, 2019). For decades, many nations have prioritized evidence-based practice (EBP) as a foundation for healthcare improvement. Both the World Health Organization (WHO) and the European Commission advocate social and health services grounded in rigorous research evidence to ensure optimal care standards (Bankole et al., 2022; WHO, 2017). Nurses, representing the largest sector of healthcare providers, require access to research-driven data to support their practice effectively (Akingbade et al., 2023). By integrating the best available evidence into clinical decision-making, nurses are expected to improve patient outcomes and the quality of care (De Leo et al,, 2019). EBP involves systematically forming clinical questions, gathering and analyzing evidence, and incorporating clinical expertise alongside patient preferences to guide care (Disler et al., 2019). This approach combines current evidence with clinical judgment and patient values, forming the basis of well-informed healthcare decisions (Katowa-Mukwato et al., 2021).

Nurses provide personalized care, support families, and contribute significantly to public health, particularly in the management of both infectious and chronic diseases (Arowolo et al., 2023). To maximize efficacy, they must integrate clinical skills with high-quality scientific knowledge, a core element of evidence-based medicine (Atkinson et al., 2017). While the implementation of EBP requires behavioral shifts among providers and structural adjustments across systems, its adoption is shown to improve service quality, elevate care standards, and reduce healthcare costs (Pitsillidou et al., 2021; Shin & Lee, 2017). High-value care is both a professional obligation for nurses and a fundamental patient right, fostering scientific and clinical advancements within the profession (Liu & Aungsuroc, 2018).

In rural settings, factors such as nurses' knowledge of EBP, access to resources, and organizational support significantly influence care quality (Schaefer & Welton, 2018). Common barriers to EBP include insufficient training, funding limitations, and resource constraints (Pitsillidou et al., 2021). Effective EBP implementation strategies emphasize leadership support, readiness, adherence to evidence-based guidelines, and targeted training, though the majority of research focuses on hospital-based nurses. Community nursing, due to its distinct context and demands, requires specialized implementation strategies. Educational approaches such as lectures, feedback, and reminders are commonly employed, although alternative strategies remain underexplored in community settings (Mathieson et al., 2019).

Background: Clinical decision-making (CDM) is a core process through which nurses make daily patient care decisions, involving the selection among alternatives and significantly impacting patient outcomes and safety (Krishnan, 2018; Farčić et al., 2020). The capacity of nurses to employ critical thinking in CDM is crucial and depends on both comprehensive knowledge and practical expertise (Manetti, 2019). In the community healthcare setting, where nurses often work autonomously, particularly within public health programs, they rely on a blend of clinical and public health skills. This independent practice, frequently conducted without direct physician oversight, necessitates advanced critical thinking and decision-making capabilities (Li et al., 2019; WHO, 2017).

There are significant disparities in evidence-based practice (EBP) knowledge and skills among healthcare professionals across developed and low-income countries (Abdulwadud et al., 2019). While industrialized nations have made considerable progress in EBP, its adoption in African countries remains slow, largely due to systemic barriers such as limited resources and infrastructural challenges (Garcia et al., 2019; Lizarondo et al., 2019). The implementation of EBP contributes to improved patient safety, better clinical outcomes, and increased job satisfaction among healthcare providers (Atakro et al., 2020). However, its adoption is hindered by challenges such as time constraints, workforce shortages, and limited familiarity with EBP principles (Mathieson et al., 2019).

Current research on EBP within community nursing, particularly in non-European regions such as Nigeria, is limited. In low- and middle-income countries (LMICs), where the burden of disease is high, the integration of evidence-based approaches is essential. However, resource limitations and high workloads present obstacles to EBP implementation (Edwards et al,, 2019). In Ondo State, Nigeria, community nurses face challenges including inadequate resources, unreliable electricity, and limited access to research materials, contributing to suboptimal clinical outcomes and a higher incidence of medical errors

(Degu et al., 2022). These findings underscore the need for targeted research to assess the factors influencing EBP in clinical decision-making within primary healthcare settings in such regions. By systematically implementing EBP, healthcare facilities can enhance patient safety and improve care quality.

Theoretical Underpinning of the Study: The Theory of Innovation Diffusion (TID), first conceptualized by E.M. Rogers in 1962, provides a framework for understanding the spread of ideas or products, such as new evidence-based practice (EBP) methodologies, within communities over time (LaMorte, 2022). This diffusion process involves analyzing key innovation attributes, with successful implementation influenced by relative advantage, compatibility, simplicity, observability, and trialability (Dearing & Cox, 2018). Innovation adoption is more likely when relevant organizations actively participate and when the supporting environment fosters it.

Rogers' model describes critical stages in the adoption process: knowledge, persuasion, and decision-making (Figure 1). In the knowledge phase, individuals become aware of the innovation and acquire an understanding of its mechanisms. The persuasion phase involves forming attitudes toward the innovation based on perceived benefits, usability, and adaptability, with influencing factors including organizational support, training, mentorship, and barriers such as increased workload (McWilliams & Mehrotra, 2018). Finally, in the decision stage, individuals either adopt or reject the innovation, guided by the combined impact of these factors.
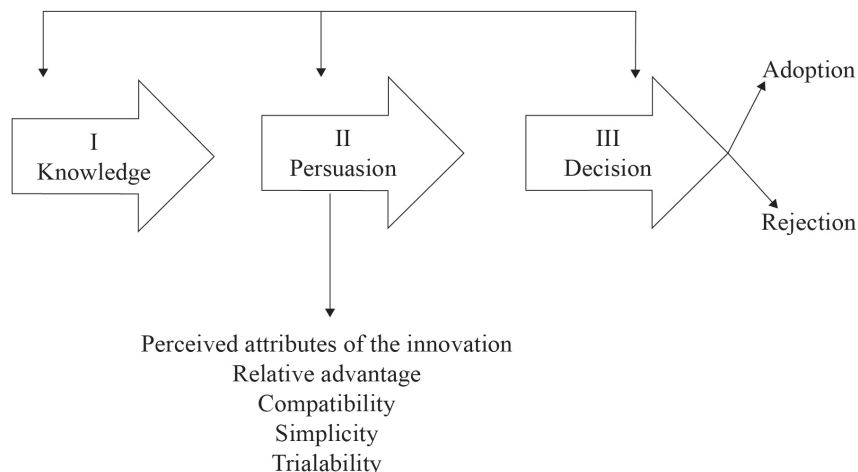

Figure 1. **Rogers' diffusion of innovation model** (adopted from Dearing & Cox, 2018)

Effective EBP implementation within nursing relies on evaluating how it affects health outcomes, patient and provider satisfaction, and operational efficiency, underscoring its potential as a transformative practice when integrated systematically and supported institutionally (Olabode et al., 2024).

This study aims to investigate the determinants of EBP implementation in clinical decision-making among nurses in primary healthcare facilities in Ondo State, Nigeria. The research addresses the following questions: (a) What is the level of knowledge regarding evidence-based practice in clinical decision-making among nurses in primary healthcare facilities? (b) What is the current level of EBP implementation in clinical decision-making among these nurses? (c) What determinants and strategies influence the implementation of EBP in clinical decision-making within this healthcare context?

2. METHODS

Study design. The study employed a cross-sectional correlational survey design, adhering to the STROBE (Strengthening the Reporting of Observational Studies in Epidemiology) reporting guidelines to ensure transparency and methodological rigor.

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Study Setting. The study was conducted among nurses employed across all primary healthcare facilities in Ondo State, situated in the southwestern humid forest region of Nigeria, at latitudes 5°45'N to 8°15'N and longitudes 4°45'E to 6°00'E. Ondo State comprises 584 primary healthcare institutions distributed across 18 Local Government Areas (LGAs) within its three senatorial districts – southern, central, and northern (Atim & Bhatnagar, 2013; Ondo State Primary Health Care Development Agency [SPHCDA], 2022). The study population included all registered nurses working in these facilities, with records from the Ondo State Ministry of Health indicating a total of 327 nurses (SPHCDA, 2022).

The sample size was determined using Slovin's formula, appropriate for a finite and known population size. Assuming a 95% confidence level and a 5% margin of error, the initial calculated sample size was 180. Given the relatively small population size, however, a total enumeration sampling technique was employed to include all 327 nurses from Ondo State's primary health care facilities, ensuring a comprehensive representation (Akingbade et al., 2023b).

Inclusion Criteria. The inclusion criteria encompassed all nurses working within primary healthcare facilities in Ondo State who were willing to participate in the study.

Exclusion Criteria. The study excluded nurses unwilling to participate and those employed in school clinics across the State.

Instrument Validity. To ensure the validity of the instrument, the researcher sought expert feedback from the project supervisor, who reviewed the questionnaire for relevance and clarity. Necessary adjustments were made prior to administering the survey to participants.

Instrument Reliability. The instrument's reliability was assessed using the internal consistency method. A pilot study was conducted on a sample of 33 nurses (representing 10% of the main study's population) from primary healthcare facilities in Osun State, chosen for their similarity to the study population but were not included in the main study. This pre-test ensured participants' understanding of each question and validated the questionnaire format. Reliability was confirmed through a Cronbach's alpha coefficient of 0.772, indicating high internal consistency.

Data Collection and Analysis. Data were collected from October 2022 to July 2023 using an online survey platform (Google Forms). Out of 327 registered nurses, 266 completed and submitted the survey, representing approximately 80% of the sample. To ensure response quality, the survey required completion of all items before submission. Responses were downloaded in Excel format, and Statistical Package for the Social Sciences (SPSS) version 26 was used for data analysis. Descriptive statistics, including frequency distribution tables, percentages, and bar charts, were employed to present the findings.

Demographic Data Analysis. Section A of the questionnaire captured socio-demographic data, which were analyzed descriptively, with frequency-percentage tables used to display quantitative variable indices.

Objective 1: Knowledge of EBP in Clinical Decision-Making. Knowledge levels were evaluated through responses to questions 1–10 in section B. Responses were categorized as 'Good Knowledge' (8–10 points) and 'Poor Knowledge' (0–7 points), with a mean score of 8 and an SD of 1.58. Each correct response received one point, and questions were standardized for positive framing.

Objective 2: Implementation Level of EBP in Clinical Decision-Making. The level of EBP implementation was assessed through questions 1–11 in section C, using a Likert scale for responses, scored as: Strongly Agree (5), Agree (4), Undecided (3), Disagree (2), and Strongly Disagree (1). High implementation was defined as scores between 42–55 and low implementation as 0–41, with a mean of 42.3 and an SD of 7.21.

Objective 3: Determinants and Strategies Influencing EBP Implementation. Questions 1–13 in section D examined the determinants and strategies affecting EBP in clinical decision-making, presented descriptively in frequency-percentage tables. Responses followed a similar Likert scale as in objective 2.

Ethical Considerations: The study was conducted in compliance with ethical standards. Approval was granted by the Ondo State Health Research Ethics Committee (protocol number OSHREC

01/08/22/462). Supporting documentation, including a research proposal and departmental endorsements, was provided to the Ondo State Ministry of Health, the State Primary Health Care Development Agency, and the Director of Nursing Services. Permission to access the study population was secured, and informed consent was obtained from all participants before data collection.

3. RESULTS

Socio-demographic and professional data: The majority of respondents were female (94.7%), with males comprising 5.3% of the sample. The predominant age group was 31–40 years, representing 45.1% of the respondents, followed by the 21–30 years age group, which accounted for 33.5% (Table 1).

Table 1. **Socio-demographic characteristics (n= 266)**

Variable	Responses	Frequency (%)
Sex	Male	14 (5.3)
	Female	252 (94.7)
Age group (in years)	21–30	90 (33.8)
	31–40	119 (44.7)
	41–50	20 (7.5)
	51–60	37 (13.9)
Marital status	Single	51 (19.2)
	Married	215 (80.8)
	Divorced	Nil
Nursing qualification	Diploma	100 (37.6)
	BNSc	162 (60.9)
	MNSc	4 (1.5%)
	PhD	Nil
Professional cadre	NO II	60 (22.6)
	NO I	30 (11.3)
	SNO	48 (18.0)
	PNO	73 (27.4)
	ACNO	5 (1.9)
	CNO	31 (11.7)
	ADNS	8 (3.0)
	DNS	11 (4.1)
Years of experience (in years)	0–3	33 (12.4)
	4–9	123 (46.2)
	10 and above	110 (41.4)

Note: Director of Nursing Services (DNS): the individual is in charge of all the Nurses working in all the Primary Healthcare Facilities in State and oversees their activities. Assistant Director of Nursing Services (ADNS): they assist the DNS and report to the individual. Chief Nursing Officer (CNO): in most cases head the local healthcare institution, and oversees the activities of the Nurses in their institution. Assistant Chief Nursing Officer (ACNO): the individuals assist the CNO. Principal Nursing Officer (PNO): they are next to the ACNO in rank. SNO: Senior Nursing Officer, they are next to the PNO in rank. Nursing Officer I (NO I):, they are next to the SNO in rank. Nursing Officer II (NO II): they are the least cadre of Nurses and are next to the NO I in rank.

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Knowledge of Evidence-Based Practice in Clinical Decision-Making: All participants (100%) reported awareness of Evidence-Based Practice (EBP), with 99.6% acknowledging that EBP is a problem-solving methodology utilized in healthcare delivery. A similar proportion (99.6%) recognized that EBP integrates scientific research with clinical expertise, as well as patient preferences and values, with 100% affirming the importance of these factors. Approximately 79% of respondents identified EBP as being patient-centered. Over two-thirds of participants (more than 66%) understood that EBP enhances clinical decision-making skills among nurses, enabling them to incorporate the latest research findings and align their practice with current healthcare standards, thereby contributing to both organizational outcomes and patient care.

A majority (83.8%) of respondents were familiar with the procedural steps involved in EBP, and about 74% demonstrated sufficient knowledge regarding its implementation (Table 2).

In terms of the overall level of knowledge, 73.7% of respondents exhibited good knowledge of EBP in clinical decision-making, while the remaining 26.3% demonstrated poor knowledge of this approach.

Table 2. **Knowledge of evidence-based practice in clinical decision-making** (n =266)

Variables	Yes (n, %)	No (n, %)	I don't know (n, %)
Have heard about evidence-based practice	266 (100)		
EBP is a problem-solving approach to health care delivery	265 (99.6)	1 (0.4)	
EBP integrates scientific research with clinician expertise, patient preferences and values	266 (100)		
EBP is the cornerstone for improving the quality and safety of patient care	264 (99.2)	2 (0.8)	
EBP is patient centered	209 (78.6)	34 (12.8)	23 (8.6)
EBP enhances nurses clinical decision-making skills	259 (97.4)	7 (2.6)	
EBP does not include the use of data obtained from scientific research in nursing clinical practice	215 (80.8)	29 (10.9)	22 (8.3)
EBP allows nurses to use the latest research findings, keep pace with current health care practices and contribute to their organization as well as to their patients	258 (97)	8 (3)	
Clear about the steps of EBP	223 (83.8)	29 (10.9)	14 (5.3)
Know how to implement EBP sufficiently	197 (74.1)	55 (20.7)	14 (5.3)

Level of Implementation of Evidence-Based Practice in Clinical Decision-Making: Approximately 58% of respondents indicated regular implementation of evidence-based findings in addressing patient care issues, with 53.8% acknowledging the integration of scientific research with clinical expertise, patient preferences, and values. A majority (62%) of participants reported utilizing effective strategies for implementing changes based on EBP. Over two-thirds (more than 66%) of respondents agreed that the incorporation of EBP into clinical decision-making has facilitated the evaluation of outcomes following practice changes.

Around 34% of respondents reported systematically collecting patients' medical issues to provide evidence-based solutions. More than half of the respondents expressed agreement with practice changes based on patient outcome data, including the incorporation of current EBP findings in clinical

decision-making and the evaluation of care initiatives through the collection of patient outcome data. Additionally, 68% of respondents supported promoting the use of EBP among their colleagues (Table 3).

Regarding the level of EBP implementation, 53.4% of respondents demonstrated high levels of implementation, while the remaining 46.6% exhibited low levels of implementation in clinical decision-making.

Table 3. **Level of implementation of evidence-based practice in clinical decision-making** (n= 266)

Variables	Strongly agree n (%)	Agree n (%)	Undecided n (%)	Strongly disagree n (%)	Disagree n (%)
Regular implementation of evidenced based finding to patient care problem	73(27.4)	155(58.3)	17(6.4)	1(0.4)	20(7.5)
Integration of scientific research with my expertise, patient's preference and values	74(27.8)	143(53.8)	36(13.5)	9(3.4)	4(15)
Making use of effective strategies for implementing EBP practice changes	56(21.1)	165(62))	30(11.3)	10(3.8)	5(1.9)
Implementation of EBP into clinical decision-making has helped me to evaluate the outcomes of a practice change	58(21.8)	193(72.6)	6(23)	1(0.4)	8(3)
Collect data patient's medical problem in order to provide evidence -based solutions to them	66(24.8)	89(33.5)	54(20.3)	16(6)	41(15.4)
Change practice based on patient's outcome data by implementing up-to-date EBP findings to clinical decision making	54(20.3)	139(52.3)	17(6.4)	15(5.6)	41(15.4
Share new ideas and evidence-based findings with professional colleagues	23(8.6)	24(9)	28(10.5)	107(40.2)	84(31.6)
Informally discussed evidence from a research study with a colleague	29(10.9)	178(66.9)	39(14.7)	19(7.1)	1(0.4)
Used an EBP guideline/systematic review to change clinical practice where I work	74(27.8)	105(39.5)	50(18.8)	4(1.5)	33(12.4)
Evaluated a care initiative by collecting patient outcome data	45(16.9)	146(54.9)	65(24.4)	1(0.4)	9(3.4)
Promoted the use of EBP to my colleagues	72(27.1)	181(68)	5(1.9)		8(3)

Determinants and Strategies for the Implementation of Evidence-Based Practice in Clinical Decision-Making: Approximately 64% of respondents agreed that the ability to read and critically assess nursing research reports, determine the scientific merit of the research, and evaluate its relevance to nursing practice, significantly influences the implementation of evidence-based practice (EBP) in clinical decision-making. More than half of the respondents (over 50%) believed that a reduced workload, facilitated by adequate staffing, supports the ability to stay current with new scientific findings and positively impacts the implementation of EBP.

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A substantial proportion (57.9%) of respondents strongly agreed that sponsoring nurses for workshops and programs related to EBP would promote its adoption in clinical decision-making, thereby influencing its implementation. In contrast, more than two-thirds of respondents disagreed that there was sufficient training for effective participation in multidisciplinary teams, which could influence the implementation of EBP.

Approximately 48% of respondents disagreed that they had confidence in evaluating the quality of research, while 56.8% felt that the infrastructure for research-related activities was inadequate, both of which were seen as barriers to effective EBP implementation. Additionally, over two-fifths of respondents identified a lack of understanding of online research databases, such as CINAHL and MEDLINE, as a significant determinant in the implementation of EBP (Table 4).

Table 4**. Determinants and strategies of implementation of evidence-based practice in clinical decision-making**

Variables	Strongly agree n (%)	Agree n (%)	Undecided n (%)	Strongly disagree n (%)	Disagree n (%)
Ability to read nursing research report, decide if the research has scientific merit and how it relates to nursing practice do influence its implementation to clinical decision-making	81(30.5)	169(63.5)	11(4.1)		5(1.9)
Less workload in terms of provision of adequate manpower helps to keep up-to-date with all the new scientific findings	116(43.6)	146(54.9)	3(1.1)	1(0.4)	
The availability of EBP resources and full support from the state primary health care board improves application of EBP to clinical decision-making	113(42.5)	113(42.5)	4(1.5)	7(2.6)	29(10.9)
Sponsoring of nurses for EBP-related workshops and programs will encourage the application of EBP to clinical decision-making	154(57.9)	110(41.4)	2(0.8)		
A therapeutic communication system between various health care professionals will facilitate the integration of EBP to clinical decision-making in primary health care facilities	145(54.5)	110(41.4)	2(0.8)	5(1.9)	4(1.5)
Do not have access to a good network here, so I am not able to access online scientific journals.	60(22.6)	53(19.9)	80(30.1)	21(7.9)	52(19.5)
There is an electricity supply, have access to the internet	19(7.1)	95(35.7)	37(13.9)	47(17.7)	68(25.6)
There is time to implement EBP	16(6)	94(35.3)	69(25.9)	15(5.6)	72(27.1)

There is training in order to participate effectively in multidisciplinary teams	11(4.1)	16(6)	32(12)	16(6)	191(71.8)
There is confidence in evaluating the quality of the research	16(6)	40(15)	63(23.7)	20(7.5)	127(47.7)
There is an infrastructure for research-related activities	7(2.6)	20(7.5)	37(13.9)	51(19.2)	151(56.8)
Lack of understanding of online research databases such as CINAHL and MEDLINE	43(16.2)	123(46.2)	60(22.6)	10(3.8)	30(11.3)
I think I am interested in implementing EBP	108(40.6)	91(34.2)	51(19.2)	8(3)	8(3)

Note: CINAHL: Cumulated Index to Nursing and Allied Health Literature. MEDLINE: Medical Literature Analysis and Retrieval System Online.

Hypothesis Testing. Hypothesis One. Null Hypothesis (H_0): There is no significant association between the socio-demographic characteristics of nurses (age, level of education, years of experience) and knowledge of evidence-based practice (EBP) in clinical decision-making among nurses.

Table 5 presents the association between respondents' socio-demographic characteristics and their knowledge of EBP in clinical decision-making. The data indicate that the proportion of respondents with good knowledge of EBP in clinical decision-making was significantly higher among single respondents (86.3%) compared to their married counterparts (70.7%), with a p-value < 0.05. Furthermore, a higher proportion of good knowledge was observed among respondents holding the position of Chief Nursing Officer (CNO) (90.3%) compared to those in other roles, such as Principal Nursing Officer (PNO) (80.8%), Nursing Officer I (NOI) (73.3%), Senior Nursing Officer (SNO) (72.9%), Nursing Officer II (NO II) (68.3%), Assistant Chief Nursing Officer (ACNO) (60%), Assistant Director of Nursing Services (ADNS) (50%), and Director of Nursing Services (DNS) (36.4%), with a p-value < 0.05.

Table 5. **Association between respondents' socio-demographics characteristics and knowledge of EBP**

Variables	Poor (%)	Good (%)	X²	p-value
Age(years)			1.91	0.591
21–30	26(28.9)	64(71.1)		
31–40	28(23.5)	91(76.5)		
41–50	4(20)	16(80)		
51–60	12(32.4)	25(67.6)		
Sex			1.10	0.294
Male	2(14.3)	12(85.7)		
Female	68(27)	184(73)		
Marital status			5.16	0.023*
Single	7(13.7)	44(86.3)		
Married	63(29.3)	152(70.7)		
Nursing qualification			3.3	0.192
Diploma	31(31)	69(69)		
BNSc	37(22.8)	125(77.2)		
MNSc	2(50)	2(50)		
Professional cadre			17.95	0.012*

NO II	19(31.7)	41(68.3)		
NO I	8(26.7)	22(73.3)		
SNO	13(27.1)	35(72.9)		
PNO	14(19.2)	59(80.8)		
ACNO	2(40)	3(60)		
CNO	3(9.7)	28(90.3)		
ADNS	4(50)	4(50)		
DNS	7(63.6)	4(36.4)		
Years of Experience			3.98	0.136
0–3	7(21.1)	26(78.8)		
4–9	27(22)	96(78)		
≥10	36(32.7)	74(67.3)		

*Statistically significant, significant association at $p < 0.05$.

Note: Director of Nursing Services (DNS): the individual is in charge of all the Nurses working in all the Primary Healthcare Facilities in State and oversees their activities. Assistant Director of Nursing Services (ADNS): they assist the DNS and report to the individual. Chief Nursing Officer (CNO): in most cases head the local healthcare institution, and oversees the activities of the Nurses in their institution. Assistant Chief Nursing Officer (ACNO): the individuals assist the CNO. Principal Nursing Officer (PNO): they are next to the ACNO in rank. SNO: Senior Nursing Officer, they are next to the PNO in rank. Nursing Officer I (NO I):, they are next to the SNO in rank. Nursing Officer II (NO II): they are the least cadre of Nurses and are next to the NO I in rank.

Hypothesis Two. Null Hypothesis (H₀): There is no significant relationship between knowledge and the level of implementation of evidence-based practice (EBP) in clinical decision-making among nurses.

Table 6 presents the analysis of the relationship between knowledge and the level of EBP implementation in clinical decision-making among nurses. The results indicate that there was no significant relationship between the nurses' knowledge of EBP and their level of implementation of EBP in clinical decision-making.

Table 6. **Association between respondents' knowledge and level of implementation of EBP**

Variables	**Knowledge**		X^2	p-value
	Good (%)	Poor (%)		
Level of implementation			0.15	0.702
Low	34 (27.4)	90 (72.6)		
High	36 (25.4)	106 (74.6)		

Hypothesis Three. Null Hypothesis (H₀): There is no significant relationship between socio-demographic characteristics and the level of implementation of evidence-based practice (EBP) in clinical decision-making among nurses.

Table 7 presents the association between respondents' socio-demographic characteristics and their level of EBP implementation in clinical decision-making. The results indicate that the proportion of respondents with a high level of EBP implementation was significantly higher among those aged 51–60 years (78.4%) compared to those in the 21–30 years (53.3%), 31–40 years (47.1%), and 41–50 years (45%) age groups, with a p-value < 0.05. Additionally, a higher proportion of respondents with a high level of implementation were Chief Nursing Officers (CNO) (74.2%), compared to those holding other positions, such as Director of Nursing Services (DNS) (72.7%), Nursing Officer II (NO II) (66.7%), Senior Nursing

Officer (SNO) (60.4%), Principal Nursing Officer (PNO) (38.4%), and Nursing Officer I (NO I) (30%), with a p-value < 0.05.

Table 7. **Association between respondents' socio-demographics and level of implementation of EBP**

Variables	Low (%)	High (%)	X^2	p-value
Age (years)			11.77	0.008*
21–30	42(46.7)	48(53.3)		
31–40	63(52.9)	56(47.1)		
41–50	11(55)	9(45)		
51–60	8(21.6)	29(78.4)		
Sex			3.77	0.052
Male	3(21.4)	11(78.6)		
Female	121(48)	131(52)		
Marital status			3.78	0.052
Single	30(58.8)	21(41.2)		
Married	94(43.7)	121(56.3)		
Nursing qualification			1.01	0.604
Diploma	45(45)	55(55)		
BNSc	78(48.1)	84(51.9)		
MNSc	1(25)	3(75)		
Professional cadre			31.47	0.000*
NO II	20(33.3)	40(66.7)		
NO I	21(70)	9(30)		
SNO	19(39.6)	29(60.4)		
PNO	45(61.6)	28(38.4)		
ACNO	5(100)	0(0)		
CNO	8(25.8)	23(74.2)		
ADNS	3(37.5)	5(62.5)		
DNS	3(27.3)	8(72.7)		
Years of experience			2.08	0.353
0–3	15(45.5)	18(54.5)		
4–9	63(51.2)	60(48.8)		
≥10	46(41.8)	64(58.2)		

*Statistically significant, significant association at p < 0.05

Note: Director of Nursing Services (DNS): the individual is in charge of all the Nurses working in all the Primary Healthcare Facilities in State and oversees their activities. Assistant Director of Nursing Services (ADNS): they assist the DNS and report to the individual. Chief Nursing Officer (CNO): in most cases head the local healthcare institution, and oversees the activities of the Nurses in their institution. Assistant Chief Nursing Officer (ACNO): the individuals assist the CNO. Principal Nursing Officer (PNO): they are next to the ACNO in rank. SNO: Senior Nursing Officer, they are next to the PNO in rank. Nursing Officer I (NO I):, they are next to the SNO in rank. Nursing Officer II (NO II): they are the least cadre of Nurses and are next to the NO I in rank.

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4. DISCUSSION

This study assessed the determinants influencing the implementation of evidence-based practice (EBP) in clinical decision-making among nurses in primary healthcare facilities. The findings revealed a significant association between the socio-demographic characteristics of nurses and their knowledge of EBP in clinical decision-making. Specifically, the proportion of respondents demonstrating good knowledge of EBP in clinical decision-making was significantly higher among single nurses (86.3%) compared to their married counterparts (70.7%), with a p-value < 0.05. This may suggest that single nurses have more time to dedicate to their professional responsibilities, without the added personal commitments that may influence married nurses.

This finding aligns with the study by Alemayehu and Jevoor (2021), which explored the utilization of EBP among nurses in the South Nations, Nationalities, and Peoples of Ethiopia Region Referral Hospitals. The study found a significant association between marital status and the level of EBP implementation, with single nurses (66.2%) more likely to implement EBP than married nurses. The study suggested that marital responsibilities, particularly in the home, could impact the work-life balance of married nurses and hinder their engagement with EBP.

Additionally, a significant association was found between professional cadre and knowledge of EBP. Nurses holding higher administrative positions, such as Chief Nursing Officers (CNOs), exhibited a higher level of knowledge of EBP (90.3%) compared to nurses in lower positions such as Nursing Officer II (NO II) and Director of Nursing Services (DNS). The higher knowledge levels among CNOs could be attributed to the leadership responsibilities inherent in their roles, which may provide more opportunities to attend workshops and disseminate knowledge to subordinates who may be preoccupied with clinical duties. This is supported by Zhou et al. (2016), who found that nurses in administrative positions had higher EBP knowledge and more favorable attitudes compared to their non-administrative counterparts.

In contrast, the study also revealed no significant relationship between nurses' knowledge of EBP and the level of its implementation in clinical decision-making. This suggests a gap between the knowledge of EBP and its practical application in clinical settings. These findings are consistent with Hashish, Aly, and Alsayed (2020), who conducted a study on EBP and quality improvement among Egyptian nurses and also found no significant relationship between knowledge and implementation of EBP. However, this is in contrast to Bankole et al. (2022), who reported a significant relationship between knowledge and utilization of EBP among nurses in Nigerian tertiary hospitals. Furthermore, Yoo et al. (2019) found a positive relationship between knowledge and the level of EBP implementation in clinical nursing practice.

The study also highlighted an association between socio-demographic characteristics and the level of EBP implementation. A higher level of implementation was observed among nurses in leadership roles, such as CNOs, likely due to the managerial responsibilities and the capacity to influence clinical practices. This finding aligns with Alshammari (2021), who reported that job titles influence the implementation of EBP in clinical decision-making. Similarly, Kim et al. (2016) found that nurses in management positions had stronger EBP beliefs, which translated into higher rates of EBP implementation.

Nurses with more than 10 years of experience were more likely to implement EBP than those with fewer years of experience, reflecting the importance of experience in facilitating the adoption of EBP. This is consistent with Adejumo et al. (2023), who recommended that more experienced nurse clinicians mentor less experienced colleagues to foster the adoption of EBP. The study also found that older nurses (51–60 years) exhibited a higher level of EBP implementation, which may be attributed to their accumulated professional experience, further supporting the importance of experience in EBP implementation.

A notable barrier to the implementation of EBP identified in this study was the lack of confidence in evaluating research quality and the insufficient understanding of online research databases, such as CINAHL and MEDLINE. This underscores the need for continuous training and development programs to enhance nurses' research competencies. This finding is consistent with Akingbade et al. (2023a), who

identified a need for ongoing research training to improve EBP knowledge and skills among Nigerian nurses. Moreover, digital platforms could be a valuable tool for building research competencies, particularly in regions where internet access is available, as suggested by Akingbade et al. (2023c) and Adesuyi et al. (2023).

Study Limitations. While the study adhered to Teddlie and Yu's (2007) recommendation that a 10% sample size is representative for small populations, the study's timeframe limited the ability to obtain a fully representative sample. Additionally, the study focused exclusively on nurses in primary healthcare facilities in Ondo State, excluding those working in secondary and tertiary healthcare settings, which could have allowed for comparisons across different levels of care.

Suggestions for Further Research: Future studies could explore the determinants of EBP implementation in a comparative study across nurses working in tertiary, secondary, and primary healthcare settings. A qualitative study could provide deeper insights into the determinants influencing the implementation of EBP in clinical decision-making among nurses in primary healthcare facilities.

Implications for Nursing Practice: Nurses, as the largest workforce in healthcare, play a pivotal role in delivering patient care (Oyewumi et al., 2022). The findings of this study indicate that while nurses possess good knowledge of EBP, the level of its implementation in clinical decision-making requires further improvement. The study also identified several factors, such as inadequate training for multidisciplinary teamwork, insufficient infrastructure for research-related activities, and a lack of understanding of online research databases (e.g., CINAHL and MEDLINE), that hinder the implementation of EBP. Given the importance of EBP in enhancing patient outcomes by integrating clinical expertise with the best available evidence and patient preferences, it is essential to invest in educational and infrastructure improvements to facilitate the integration of EBP into clinical practice.

5. CONCLUSIONS AND PERSPECTIVES

This study evaluated the determinants influencing the implementation of evidence-based practice (EBP) in clinical decision-making among nurses in primary healthcare facilities. Specifically, the study assessed nurses' knowledge of EBP in clinical decision-making, determined the level of EBP implementation, and identified the key determinants and strategies impacting EBP application in clinical settings. Findings indicated that the majority of nurses possessed a high level of EBP knowledge and a strong implementation level in clinical decision-making.

Regarding determinants and strategies influencing EBP implementation, respondents reported that several factors exerted a substantial impact on their EBP application in clinical decision-making. However, a notable portion of respondents reported that they did not regularly share new evidence-based insights or findings with professional colleagues, and many did not routinely collect data on patients' medical conditions to support evidence-based interventions. Additionally, a significant proportion of respondents expressed a lack of confidence in evaluating research quality, which may inhibit effective EBP application.

To address these issues, it is recommended that targeted strategies for EBP implementation be developed. Such strategies should include policies and programs aimed at fostering a collaborative and supportive environment for EBP among healthcare providers. Furthermore, governmental policies, endorsed by leadership across primary healthcare facilities, should be established to systematically promote EBP in clinical decision-making. These initiatives will be instrumental in strengthening EBP utilization among nurses, enhancing patient care, and ensuring alignment with contemporary healthcare standards.

Definition of Terms/Abbreviations:
Nurses/Community Nurses: These are nurses in Primary Health Care Centers/rural areas who have completed the requirements in the Nursing profession and were certified to practice by their regulatory bodies.

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DNS: Director of Nursing Services, the individual is in charge of all the Nurses working in all the Primary Healthcare Facilities in State and overseas their activities.

ADNS: Assistant Director of Nursing Services, they assist the DNS and report to the individual.

CNO: Chief Nursing Officer, in most cases head the local healthcare institution, and overseas the activities of the Nurses in their institution.

ACNO: Assistant Chief Nursing Officer, the individuals assist the CNO.

PNO: Principal Nursing Officer, they are next to the ACNO in rank.

SNO: Senior Nursing Officer, they are next to the PNO in rank.

NO I: Nursing Officer I, they are next to the SNO in rank.

NO II: Nursing Officer II, they are the least cadre of Nurses and are next to the NO I in rank.

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Determinants of Implementation of Evidence-Based Practice in Clinical Decision-Making among Nurses in Primary Health Care Facilities

Veiksniai, lemiantys įrodymais grįstos praktikos įgyvendinimą priimant klinikinius sprendimus tarp pirminės sveikatos priežiūros įstaigose dirbančių slaugytojų

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Santrauka

Tyrimo pagrindimas. Sveikatos priežiūros darbuotojai ir įstaigos dažnai susiduria su įrodymais grįstos ir ekonomiškai veiksmingos priežiūros stygiumi. Šių trūkumų pašalinimas galėtų pagerinti klinikinę praktiką ir gydymo rezultatus.

Tikslas. Įvertinti veiksnius, lemiančius įrodymais grįstos praktikos įgyvendinimą priimant klinikinius sprendimus tarp slaugytojų pirminės sveikatos priežiūros įstaigose.

Metodai. Tyrime naudotas aprašomasis skerspjūvio projektas. Tyrime dalyvavo 266 slaugytojai iš pirminės sveikatos priežiūros įstaigų, esančių Ondo valstijoje (Nigerija). Duomenys surinkti naudojant struktūrizuotą klausimyną, administruojamą per internetinę apklausų platformą „Google Forms". Gauti duomenys pateikiami dažnių ir procentų lentelėse, o išvados analizuotos naudojant Chi kvadrato testą, taikant 5 proc. statistinio reikšmingumo lygmenį.

Rezultatai. Tyrimo rezultatai parodė, kad žinios yra pagrindinis veiksnys, lemiantis įrodymais grįstos praktikos įgyvendinimą valdant lėtines ligas pirminės sveikatos priežiūros įstaigose dirbančių slaugytojų darbe. 73,7 proc. respondentų nurodė, kad gerai išmano informaciją apie įrodymais grįstą praktiką lėtinių ligų valdyme, o aukščiausią kompetencijos lygį pademonstravo skyrių vadovai. Be to, prieiga prie įrodymais grįstos praktikos išteklių ir nuosekli darbdavių parama buvo pagrindiniai veiksniai, darantys įtaką sėkmingam įrodymais grįstos praktikos įgyvendinimui, o 86 proc. respondentų patvirtino šios paramos svarbą. Vertinant įgyvendinimo lygius, 53,4 proc. respondentų nurodė, kad įrodymais grįstos praktikos įgyvendinimas lėtinių ligų valdyme yra aukštas, o likę 46,6 proc. nurodė žemą įgyvendinimo lygį.

Išvados. Tyrimo metu padaryta išvada, kad slaugytojai įprastai gerai išmano įrodymais grįstą praktiką, o aukščiausias kompetencijos lygis nustatytas tarp skyrių vadovų. Pagrindinės kliūtys įgyvendinti įrodymais grįstą praktiką lėtinių ligų valdymo srityje yra ribotas interneto prieinamumas ir nenuoseklus elektros tiekimas.

Reikšminiai žodžiai: determinantai, įgyvendinimas, įrodymais grįsta praktika, klinikinių sprendimų priėmimas, slaugytojai