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Evidence-based nursing in action: A focused ethnographic study of knowledge use in acute care

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ABSTRACT

Introduction: Evidence-based practice (EBP) plays a crucial role in improving care outcomes in critical care settings. However, its integration into nursing practice remains challenging due to organisational hierarchies, workload pressures, and uneven access to formal knowledge. This study explores how critical care nurses access, use, and integrate knowledge, with a focus on how organisational culture, leadership, and team dynamics influence EBP implementation across two acute care sites in England.

Methods: The study adopted a focused ethnographic design, guided by Spradley's Developmental Research Sequence. Data were collected over eight months through 210 h of non-participant observation, 36 semi-structured interviews, and document analysis. Analysis was supported using NVivo 12, applying iterative thematic coding. Reflexivity and member checking were used to ensure analytical rigour and trustworthiness.

Results: Five central themes were identified: access to formal guidelines, the role of peer learning, organisational culture and hierarchy, the value of experiential knowledge, and barriers to EBP. While both sites demonstrated reliance on blended sources of knowledge, they differed in how organisational factors shaped access and engagement. Site A showed stronger support through mentorship, simulation-based learning, and active leadership. In contrast, Site B was marked by rigid structures and informal, inconsistent communication of evidence. **Conclusion:** Critical care nurses draw on both formal evidence and informal knowledge, but the conditions of their work environment influence how and when this knowledge is used. Investment in leadership, protected learning time, and inclusive communication practices is essential to support sustainable engagement with EBP in high-pressure settings.

1. Introduction

Acute care involves the timely, short-term management of patients experiencing serious illness, trauma, or acute exacerbations of chronic conditions [1]. Acute care is delivered in hospital settings such as emergency departments, medical and surgical wards, and intensive care units [2], with the primary aim being to stabilise patients quickly, prevent further deterioration, and support recovery [1,2]. Nurses working in these environments are required to respond rapidly to changing clinical needs, coordinate complex care, and collaborate with multidisciplinary teams, often under pressure and with limited resources [2,3].

Evidence-based practice (EBP) plays a central role in supporting safe, effective care in acute settings [4], and requires use of the best available

research evidence alongside clinical expertise and patient values to guide decision-making [4,5]. While the principles of EBP are well established, applying them consistently in practice remains challenging due to organisational and contextual factors [6,7].

These challenges are even more pronounced in critical care, as nurses working in high-acuity areas are expected to make quick decisions in response to complex patient needs [8,9]. These decisions often draw on a mix of clinical guidelines, peer input, past experience, and the expectations of the workplace [9]. Strictly following guidelines may not always be realistic in situations where immediate action is needed. Studies show that nurses frequently adapt protocols to fit the demands of their local context, which is shaped by staffing, workload, and institutional culture [10,11].

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These pressures are often compounded by traditional team hierarchies and power dynamics [12]. In many acute settings, nurses work within physician-led decision-making structures, which can limit their ability to influence care planning [12,13]. This can reduce autonomy and make it more difficult to engage meaningfully with new evidence, particularly where there is limited support for mentorship or team-based learning [14,15].

Although national guidelines and nursing standards highlight the importance of EBP, many acute care settings still lack the systems needed to support its consistent use [16]. For example, access to current research, time for reflection, and visible leadership support can vary widely across institutions, contributing to the ongoing gap between research and clinical practice [11]. Evidence suggests that organisational investment in professional development, mentorship, and shared governance can support EBP and improve patient outcomes [17,18].

While many studies have identified general barriers to EBP in nursing, there has been less focus on the specific challenges of evidence use in acute care. In particular, we know little about how nurses working in high-pressure environments manage the tension between formal guidance and practical realities, or how institutional culture supports or limits this work [19,20]. This study addresses that gap by exploring how nurses in critical care settings acquire, negotiate, and apply knowledge in two contrasting hospital contexts in England. The aim of this study is to examine the social, cultural, and organisational factors that shape how critical care nurses access and apply knowledge in practice. Specifically, the study addresses the following questions: (1) How do critical care nurses negotiate knowledge use within complex institutional and hierarchical environments? (2) What sources of knowledge do nurses draw on, and how are these integrated into clinical decision-making? (3) In what ways do educational background and workplace culture shape nurses' engagement with evidence-based practice?

2. Methods

2.1. Research design

We adopted a focused ethnographic approach [21] to explore how acute care nurses acquire, negotiate, and apply knowledge within high-pressure clinical settings. This approach allowed for time-efficient but in-depth engagement with contemporary healthcare environments [22,23]. The study was grounded in a constructivist epistemology, recognising that knowledge is formed through social interaction, experience, and shared meaning [24,25]. An interpretivist perspective informed how we explored nurses' professional reasoning, supported by critical reflexivity to examine how our clinical and academic backgrounds shaped the research process [26,27].

We pragmatically combined elements of social science ethnography [22] with principles from applied anthropology [28]. Rather than adhering strictly to a single tradition, we drew on methods best suited to understanding knowledge practices in healthcare. Although collective case study elements were included to compare hospital sites [29,30], the study maintained its core identity as focused ethnography. This comparative lens provided depth while preserving cultural emphasis. The COREQ checklist [31] informed the study's reporting.

2.2. The research team and reflexivity

Familiarity with the field and reflexivity were central to our approach. All but one team member were registered nurses with academic and research roles, and prior experience in critical care. None were currently employed at the study sites, which helped maintain analytical distance [32]. We adopted a passive, learner stance to minimise disruption, with observations remaining strictly non-intrusive. Power imbalances were addressed through role transparency and open-ended, non-leading questioning. Reflexivity was maintained through journaling, peer debriefings, and collaborative coding. These

measures ensured interpretations were firmly rooted in participants' experiences [33].

2.3. Study setting

The study took place in ICUs, HDUs, and CCUs at two acute care hospitals in the Midlands, England. These critical care settings were selected due to their emphasis on rapid decision-making and interdisciplinary collaboration, where EBP is most needed [3,7,10]. Sites were chosen based on discussions with nursing leaders to reflect differences in organisational structure, leadership, and knowledge-sharing practices. Site A featured structured leadership development, formal mentorship, and regular simulation. Site B had hierarchical leadership, informal mentorship, and tacit knowledge sharing. Focusing on critical care aligned with ethnographic principles, allowing exploration of cultural behaviours within clearly defined professional settings [21,23]. Access was negotiated with senior leadership, guided by feasibility of immersion, institutional support for fieldwork, and differing commitments to EBP implementation [28,29].

2.4. Participants (recruitment, sampling, and sample size)

We used purposive sampling to recruit nurses from the critical care units identified above [32,29]. The aim was to include staff actively involved in high-acuity care, where knowledge utilisation is vital [5,6]. Participants were invited through internal communications and staff briefings. Written invitations were followed by in-person meetings, and interested individuals contacted the research team directly. This approach helped to minimise gatekeeping and ensure that participation was both voluntary and informed. Thirty-six participants were recruited: 26 staff nurses (SNs), six nurse managers (NMs), and four advanced clinical practitioners (ACPs). These categories reflected distinct responsibilities in clinical decision-making and knowledge application.

Inclusion criteria were as follows: participants had to be registered nurses employed at one of the study sites, working in intensive care units (ICUs), high-dependency units (HDUs), or coronary care units (CCUs). They were required to have a minimum of one year of clinical experience in critical care settings and be directly involved in clinical decision-making or patient care delivery. Participants had to be able to give informed consent and willing to engage in both observational and interview components of the study.

Exclusion criteria included agency nurses or bank staff who were not permanently employed at either hospital site, as well as individuals who were on long-term leave or secondment during the study period. Nurses who withdrew due to work pressures or personal constraints during the study were also excluded from final analysis. Participants from both day and night shifts were included, along with representation across a range of professional bands and cultural backgrounds, to support an inclusive understanding of practice. While nurse-to-patient ratios were not a criterion for inclusion, they were recorded and considered during contextual analysis.

Demographic data including age, gender, professional band, years of experience, and ethnicity were collected to provide a more comprehensive understanding of knowledge use patterns across participant groups. These characteristics are summarised in Tables 1 and 2. To assess whether age differences might influence knowledge utilisation, an independent samples *t*-test was conducted. Although the mean age differed slightly between sites, this difference was not statistically significant ($p > 0.05$) and was therefore not a focus of analysis. Participant experience ranged from 5 to 30 years. Exposure to formal EBP education varied; some had encountered it only through postgraduate study or continuing professional development (CPD). This variation reflects broader challenges in access to EBP education across the nursing workforce [19,11], and these issues are explored further in the findings.

Table 1
Participant demographics (site A).

Participant ID	Role	Years of Experience	Highest Qualification	Age (years)	Gender	Ethnicity
A-SN1	SN	5	BSc	28	Female	White
A-SN2	SN	12	BSc	35	Female	White
A-SN3	SN	18	BSc	42	Female	White
A-SN4	SN	14	BSc	38	Female	Black
A-SN5	SN	19	MSc	45	Female	Black
A-SN6	SN	22	BSc	50	Female	Brown
A-SN7	SN	7	BSc	30	Female	White
A-NM1	NM	23	BSc	48	Female	White
A-NM2	NM	28	PhD	59	Male	White
A-NM3	NM	17	MSc	44	Female	Mixed
A-ANP1	ACP	16	MSc	41	Female	Brown
A-ANP2	ACP	21	MSc	52	Female	White
A-ANP3	ACP	11	MSc	34	Female	Mixed
A-ANP4	ACP	6	MSc	29	Female	Black
A-ANP5	ACP	26	MSc	58	Male	White
A-ANP6	ACP	19	PhD	47	Female	Brown
A-ANP7	ACP	13	MSc	40	Female	White

Footnote: PhD: Doctor of Philosophy; MSc: Master of Science; BSc: Bachelor of Science; SN: Staff Nurse; NM: Nurse Manager; ACP: Advanced Clinical Practitioner.

Table 2
Participant demographics (site B).

Participant ID	Role	Years of Experience	Highest Qualification	Age (years)	Gender	Ethnicity
B-SN1	SN	6	BSc	27	Female	White
B-SN2	SN	11	BSc	33	Female	White
B-SN3	SN	17	BSc	40	Female	White
B-SN4	SN	15	BSc	36	Female	Brown
B-SN5	SN	18	BSc	43	Female	White
B-SN6	SN	20	BSc	48	Female	Black
B-SN7	SN	8	BSc	31	Female	Black
B-SN8	SN	13	BSc	37	Female	Brown
B-SN9	SN	16	MSc	39	Female	Mixed
B-NM1	NM	22	MSc	49	Female	White
B-NM2	NM	29	PhD	61	Male	White
B-NM3	NM	18	MSc	46	Female	Brown
B-ANP1	ACP	14	MSc	42	Female	Black
B-ANP2	ACP	24	MSc	55	Female	White
B-ANP3	ACP	12	MSc	32	Female	Mixed
B-ANP4	ACP	7	MSc	28	Female	Brown
B-ANP5	ACP	27	MSc	57	Female	White
B-ANP6	ACP	20	PhD	50	Male	White
B-ANP7	ACP	14	MSc	41	Female	White

Footnote: PhD: Doctor of Philosophy; MSc: Master of Science; BSc: Bachelor of Science; SN: Staff Nurse; NM: Nurse Manager; ACP: Advanced Clinical Practitioner.

2.5. Data collection

Data collection was conducted over an eight-month period from February to September 2022, following a two-month pre-fieldwork phase between November 2021 and January 2022. This preparatory period involved negotiating access, securing relevant approvals, and conducting site familiarisation and rapport-building meetings with clinical leads. These early engagements were critical for building trust, reducing field resistance, and laying the foundations for culturally sensitive and ethically sound ethnographic work [22,34].

The longitudinal nature of the data collection allowed for deep immersion across a range of seasonal, organisational, and clinical conditions, which supported the thick description of routine practices and atypical events alike [35,36]. The extended timeframe also facilitated theoretical sensitivity and analytic reflexivity, ensuring that emerging insights could be explored iteratively and triangulated across methods [24].

COVID-19 infection control procedures were strictly adhered to throughout the fieldwork. These included the consistent use of personal protective equipment, adherence to isolation procedures where relevant, and limiting non-essential in-person contact. These measures complied with institutional and national guidelines in place during the study period [31].

Data collection methods comprised non-participant observation, semi-structured ethnographic interviews, and document analysis. These were supplemented with detailed field notes and analytic memos to support interpretive depth and data triangulation [25,37]. Each method is described below.

2.5.1. Observation

Participant observation was central to this ethnographic study and enabled an in-depth exploration of how knowledge was enacted, interpreted, and negotiated in real time. The first author conducted all observations, adopting a non-participant, overt observer stance across both sites. Observer status was made explicit through visible badges, verbal introductions, and the use of neutral clinical attire. This approach helped reduce ambiguity and reinforce transparency [21,38].

A total of 56 observation sessions were conducted, each lasting between three and five hours, resulting in approximately 210 h of direct clinical observation. These sessions were purposively distributed across day, evening, and night shifts, including weekends, to capture variations in clinical intensity, team composition, and decision-making rhythms [34]. Observations were equally allocated across ICU, HDU, and CCU settings within both hospitals, providing a balanced view of critical care environments.

Spradley’s [21] Developmental Research Sequence (DRS) was used

to structure observation, progressing from descriptive observation (environmental mapping and general routines) to focused (knowledge interactions and communication patterns), and finally to selective observation (specific mechanisms of evidence mobilisation, such as mentorship, hierarchy, or resistance to protocols). This iterative movement enhanced theoretical sensitivity and interpretive nuance.

To mitigate observer bias, multiple strategies were employed. These included maintaining a “learner” stance [26], journaling reflective memos after each session to examine assumptions and positionality [27], and regularly discussing field impressions with co-researchers to surface blind spots and confirm emerging interpretations [36]. In addition, we reaffirmed voluntary participation at each session, invited staff to opt out of specific interactions, and obtained ongoing verbal consent throughout. These techniques helped reduce the potential for reactivity and reinforced ethical engagement [37,22].

Field notes were recorded in real time or shortly after each observation and included detailed accounts of clinical decisions, interpersonal exchanges, leadership behaviours, interruptions, and contextual factors such as staffing levels, acuity, and cultural norms. These notes were analytically annotated during the field period and linked to themes developed during interview and document analysis.

Ethical closure was achieved through scheduled debriefing sessions with nurse managers and unit leaders, in which emerging findings were discussed and validated. Participants were thanked, and written follow-up was provided to clinical areas. This process supported transparency, mutual respect, and reciprocity [39].

2.5.2. Ethnographic interviews

Interviews were conducted after initial field immersion to ensure that observed patterns and informal practices could be explored in depth through participant narratives. Thirty-six semi-structured interviews were completed across both sites with staff nurses, nurse managers, and advanced clinical practitioners. Interviewing after observation supported methodological triangulation and the refinement of prompts to align with site-specific dynamics [24,38].

The first and third authors jointly conducted the interviews. They were held in private rooms within the hospitals to minimise disruption and promote psychological safety. Interviews ranged from 60 to 120 min, depending on participant availability and the pace of discussion. Interview guides followed Spradley’s [21] model, moving from descriptive to structural and contrast questions. Field observations informed the content of questions, allowing the research team to investigate how staff perceived, rationalised, or contested behaviours noted during observations.

Examples of interview questions are shown in Table 3. These illustrate how real-time clinical judgements, cultural norms, leadership influence, and institutional routines were probed to understand knowledge use as a social process.

2.5.3. Review of documentation

Document analysis was a core data collection method that complemented observation and interview findings. It was used to explore how formal policies, procedural guidance, and governance structures shaped the knowledge environment in each site [40].

Documents reviewed included sepsis and airway management protocols, drug administration guidelines, training schedules, staff development frameworks, governance meeting minutes, audit summaries, policy updates, and locally adapted mentorship handbooks. These materials were obtained through clinical educators, quality improvement leads, and ward managers. Document analysis occurred iteratively throughout the field period. For instance, when a new guideline was referenced in practice, it was cross-checked against the written version, and its update frequency was verified through hospital policy logs. Similarly, staff accounts of how information was disseminated were compared with governance records to identify alignment or discrepancies between organisational intent and practice. To ensure analytic

Table 3
Sample of interview guide.

Descriptive Question	Structural Question	Contrast Question
During your shift, what types of information do you typically use when making clinical decisions?	How do you usually incorporate new knowledge or guideline updates into your practice?	When you have to act quickly, how does following formal guidelines differ from using your own clinical experience or intuition?
Can you describe how you usually share information or updates with your colleagues during a shift?	What formal or informal routines exist in your unit to support knowledge sharing among staff?	How would you compare what happens during scheduled team meetings to the informal discussions that happen during handovers or breaks?
During observations, I noticed that updates to protocols were sometimes discussed briefly at shift handovers. Can you tell me more about how these updates are usually communicated and acted upon?	In your experience, how do staff respond when a new guideline contradicts established practices based on prior experience?	How does the unit culture influence whether people rely more on written protocols or their personal and team experiences?

rigour, we excluded researcher-generated content (such as field notes and memos) from the document corpus to maintain a clear boundary between organisational discourse and interpretive narrative [41]. A summary table of the document types reviewed, their sources, and how they contributed to theme development is provided below (Table 4). This enhances methodological transparency and illustrates how documents were used to contextualise and triangulate observational and interview data.

2.6. Data analysis

Data analysis was carried out concurrently with data collection, in line with the iterative, inductive, and reflexive principles of focused ethnography [22,23]. This iterative approach allowed early insights from field engagement to shape subsequent data collection strategies. As patterns began to emerge, they were explored in greater depth through focused observations and targeted interview prompts. The first author, a registered nurse academic with expertise in qualitative research, critical care, and evidence-based practice, led the data analysis process, ensuring close integration between ethnographic fieldwork and analytical interpretation.

Spradley’s DRS was used to guide analysis, comprising three key stages: domain, taxonomic, and componential analysis [21]. In the initial stage, broad cultural domains were identified across the dataset, such as guideline access, peer mentorship, leadership practices, experiential learning, and resource constraints. NVivo 12 qualitative data analysis software was used to manage and organise the data during this

Table 4
Summary of documents reviewed.

Document Type	Source	Relevance to Theme Development
Clinical guidelines	ICU governance leads	Examined for updates, use in decision making, and accessibility
Airway checklists	Education departments	Used to compare observed practice with protocol specifications
Staff training logs	Workforce/hr departments	Identified formal CPD provision and gaps in EBP education
Mentorship frameworks	Practice development leads	Explored role of preceptorship and informal learning mechanisms
Audit reports and meeting minutes	Quality and risk teams	Revealed institutional narratives of compliance and improvement
Policy and procedure updates	Trust intranet archives	Cross referenced with staff reports of dissemination processes

phase, enabling systematic coding of interviews, observation fieldnotes, and documents.

Domain analysis involved identifying cover terms and included terms within participants' language and actions, allowing the research team to map how knowledge-related behaviours and beliefs were expressed in context. Taxonomic analysis was then used to explore the internal structure of these domains, with particular attention to the relationships between formal and informal knowledge pathways, structured versus organic mentorship practices, and knowledge access across professional hierarchies (for example, SNs compared with ACPs). This level of analysis made visible the cultural logic underpinning observed practices and highlighted implicit contrasts across both sites [21,42]. In the componential analysis stage, differences were systematically explored across participant groups and between the two hospital sites. This involved contrasting how various roles (for example, NMs versus SNs) interpreted and enacted evidence-based knowledge, particularly in relation to leadership engagement, resource availability, and adherence to clinical guidelines. Analytical memos were used throughout to track evolving interpretations, document reflexive insights, and capture contextual variations [24,36].

Thematic synthesis followed these interpretive stages and resulted in the identification of five overarching cultural themes as presented in Fig. 1. Inductive open coding was applied line by line to all transcripts and fieldnotes. Codes were then refined and grouped into higher order categories, reflecting both semantic content and latent meaning. To enhance coding rigour and analytical credibility, a second member of the research team (an experienced qualitative methodologist) independently double coded 25 % of the dataset. Coding discrepancies were discussed in team debriefings and resolved through consensus, ensuring that interpretations remained grounded in participant narratives [33].

Document analysis was conducted using directed content analysis [43], guided by the initial field-based domains. This allowed for the triangulation of observed and reported behaviours with written policies, governance documentation, and training protocols. For example, guideline dissemination practices observed in clinical units were compared with the content and update frequency of the hospital's documented policy procedures. Educational attainment was noted analytically where it shaped access to, or confidence in, using evidence-based resources, although it was interpreted as a contextual rather than causal factor in shaping knowledge use [39,44].

Member checking was undertaken during the theme development

phase. Participants were provided with anonymised summaries of emerging interpretations and invited to comment on their resonance with lived experience. Feedback was incorporated into the analysis to support credibility and authenticity [45].

2.7. Trustworthiness

Rigour was maintained through triangulation, analytic transparency, and reflexive practices. Data from observations, interviews, and documents were cross compared to support interpretive depth and credibility [25,28]. A clear audit trail was developed, documenting coding iterations, theme refinement, and analytic decisions. Independent double-coding of a subset of data by a second researcher enhanced confirmability, with discrepancies resolved through consensus [33,44].

Credibility was further supported through member checking, where selected participants reviewed summary findings to ensure alignment with their experiences [45]. Reflexivity was embedded throughout, with the lead researcher maintaining a journal to document positionality and interpretive shifts [26]. Regular team debriefs enabled critical reflection on assumptions, supporting analytical integrity [24,27].

2.8. Ethical considerations

Ethical conduct was integral to this study's design, implementation, and dissemination. The research was approved by the University Research Ethics Committee (Reference ID: UoB/00,184). This ensured full compliance with UK national research regulations and the principles outlined in the Declaration of Helsinki [46,47].

All participants were provided with detailed information about the study aims, procedures, and their rights, including the right to withdraw at any time. Written informed consent was obtained prior to participation, with verbal reconfirmation before each observation and interview session. Participant autonomy was respected throughout, and consent was treated as an ongoing process rather than a single event [45,48]. Participant information sheets were circulated well in advance via email and revisited during individual meetings to confirm understanding. The research team made efforts to ensure that consent processes were inclusive and accessible, accounting for variations in shift patterns and clinical workload.

The nature of ethnographic research in clinical environments requires particular attention to the rights and welfare of third parties unintentionally observed. In this study, non-nursing individuals who were present during observations but were not formal participants were provided with an explanation of the research and given the option to verbally decline inclusion. No data were retained from such individuals unless explicit consent was granted. Where critical incidents occurred during fieldwork, the researcher adopted a passive stance, avoiding interference and maintaining a strictly observational role, as advised in observational research guidance in high-risk settings [34,22].

3. Results

This section presents the findings of the study, structured around five interconnected themes generated through iterative thematic analysis. These themes represent the complex and layered ways in which acute care nurses engage with, adapt, and apply knowledge in critical care settings. The analysis integrates data from interviews, non-participant observations, and documentary sources, and is informed by a constructivist epistemology and a focused ethnographic lens.

Findings are reported comparatively across Sites A and B to highlight both commonalities and contextual distinctions in how knowledge is accessed, interpreted, and enacted. Data extracts include direct participant quotations, excerpts from fieldnotes, and supporting observations, with clear identifiers for context. This layered approach helps to illuminate how organisational structures, leadership behaviours, cultural norms, and experiential learning interact to shape evidence-based

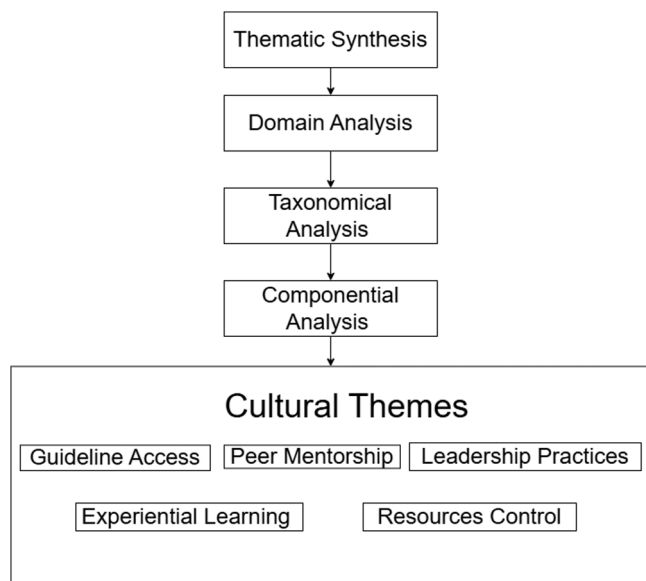


Fig. 1. Stages of thematic synthesis leading to the identification of cultural themes.

nursing practice on the ground. A summary of the themes, subthemes, and sample supporting data is presented in Table 5. These findings are also mapped thematically in Fig. 1 (see Section 2.6), which offers a visual synthesis of the relational dynamics shaping knowledge utilisation in acute care nursing practice.

The following sub-sections explore each theme in turn, beginning with the foundational issue of how nurses access formal guidelines and informal learning opportunities within their immediate clinical environments.

3.1. Sources of knowledge and knowledge acquisition

3.1.1. Access to formal guidelines and protocols

Access to formal guidelines varied considerably across sites, shaping the reliability and consistency of evidence use. In Site A, nurses consistently described a structured culture of guideline dissemination supported by governance processes and leadership visibility. Updated protocols were actively shared, discussed, and embedded into routine practice.

“We have monthly clinical governance meetings where we discuss the latest guidelines. If there’s an update, we are briefed immediately, and this helps ensure we apply evidence correctly” (A-NM2).

Observations supported this process. Laminated sepsis protocols were distributed and reviewed during team briefings (Observation 22, Site A, ICU). Documentation showed a six-month review cycle and routine sign-off processes (Document Analysis, Site A Governance Policy).

Reflective notes highlighted that protocols in Site A were visibly present in the clinical environment and regularly referenced, which normalised their use. In contrast, Site B lacked systematic processes for guideline dissemination. Staff in Site B largely depended on colleagues for updates or continued to use outdated paper copies.

“If I’m unsure about something, I ask a senior nurse or the doctor. We don’t have a lot of formal training, so most of what I learn is from watching others” (B-RN4).

This informal learning was corroborated during observations, where a three-year-old protocol manual was seen in active use (Observation 27, Site B, HDU). Site B’s policies stated only that guidelines “should be updated periodically,” offering little clarity or consistency in practice. These findings suggest that where guidelines were embedded in both policy and culture (as in Site A), EBP engagement was stronger.

These findings reflect broader organisational readiness for EBP, where embedded systems and active dissemination practices shape how evidence is normalised in routine care.

3.1.2. Role of peer learning and mentorship

Mentorship and peer learning were central to knowledge acquisition, although structured differently across the two sites. Site A offered formalised mentorship, including preceptorship for new staff. This created opportunities for deliberate knowledge transfer grounded in clinical reasoning and current best practices.

“New nurses shadow experienced staff for a few weeks, which helps them understand how we apply knowledge in practice” (A-SN3).

These learning interactions were directly observed, such as during ventilator training where protocol adherence was modelled (Observation 12, Site A, HDU). In contrast, Site B relied on informal peer support without standardised mentorship structures.

“We learn from each other a lot. If one person attends a training, they usually pass the information along informally. Sometimes it’s just a quick chat during handover or paperwork” (B-NM3).

The Site B induction booklet confirmed that peer support was encouraged but not mandatory (Document Analysis, Site B Induction

Table 5

A summary of key themes/subthemes and raw quotes.

Theme	Subtheme	Illustrative quotes
Sources of knowledge and knowledge acquisition	Access to formal guidelines and protocols	<p>“We have monthly clinical governance meetings where we discuss the latest guidelines” (A-NM2)</p> <p>Observed team briefing: laminated updated sepsis protocols distributed and discussed (Observation 22, Site A, ICU)</p> <p>Policy folders are visibly available and updated every six months, as per documentation review (Document Analysis - Site A Governance Policy)</p> <p>Protocols felt visibly embedded in daily routines at Site A but appeared absent in comparable shifts at Site B (Reflective Journal)</p>
	Role of peer learning and mentorship	<p>“New nurses shadow experienced staff for a few weeks, which helps them understand how we apply knowledge in practice” (A-SN3)</p> <p>Observation: senior nurse coaching a new nurse on ventilator management using ‘what works best’ rather than a manual (Observation 28, Site B, CCU)</p> <p>Staff induction booklet outlines ‘informal peer support encouraged; no mandatory mentorship’ (Document Analysis - Site B Induction Booklet)</p> <p>Peer mentorship critical but variable across shifts; heavily influenced by staffing levels. (Reflective Journal)</p>
Institutional and hierarchical influences on knowledge use	Organisational culture and decision-making	<p>“We’re encouraged to speak up during rounds and ask questions if something feels off” (A-ACP3)</p> <p>Observed MDT round: nurses questioned senior consultants about antibiotic adjustments, with active discussion (Observation 9, Site A, ICU)</p> <p>Meeting minutes show open interdisciplinary contributions were agenda items at Site A governance meetings (Document Analysis)</p> <p>Nurses in Site A visibly more comfortable suggesting changes compared to Site B (Reflective Journal)</p>
	Leadership support for knowledge use	<p>“Our nurse manager updates us regularly on policy changes and what it means for patient care” (A-NM1)</p> <p>Observation of nurse manager-led ‘policy update huddle’ before a shift start (Observation 14, Site A, HDU)</p> <p>Site B audit: ‘No formal mechanism for ensuring guideline updates are disseminated’ (Document Analysis - Audit Report)</p> <p>Leadership pivotal in normalising guideline discussions during clinical</p>

(continued on next page)

Table 5 (continued)

Theme	Subtheme	Illustrative quotes
The role of experiential knowledge and clinical intuition	The use of intuition in clinical decision-making	<i>handovers at Site A (Reflective Journal)</i>
		“Sometimes, you just know when something isn’t right, even before the vitals change” (A-SN5) <i>Observation: ACP initiated rapid intervention based on ‘gut feeling’ despite normal observations. (Observation 19, Site A)</i> <i>No formal documentation recorded intuition; policy documents emphasise protocol adherence (Document Analysis)</i> <i>Tension noted between ‘following gut’ and sticking rigidly to numeric criteria during observations (Reflective Journal)</i>
	The influence of past experiences on knowledge use	“After a similar case last year, I knew exactly what to look for” (A-SN8) <i>Observed during cardiac arrest drill: nurse referenced previous airway difficulties to anticipate alternative interventions (Observation 25, Site A)</i> <i>Training guidelines lack explicit space for reflective learning from past cases (Document Analysis)</i>
		Time constraints and workload pressures <i>Senior nurses often drew directly on case memory during emergencies more than protocols (Reflective Journal)</i> <i>“When you’re short-staffed, there’s no time to look up the latest evidence; you have to act” (A-ACP2)</i> <i>Observation: break rooms empty during shifts; no protected time seen for evidence consultation (Observation 16, Site B)</i> <i>Staff survey showed ‘high perceived workload’ as main barrier to EBP training attendance (Document Analysis - Site B Workforce Survey)</i> <i>During busy shifts, the idea of stopping to check evidence seemed unrealistic - action took precedence. (Reflective Journal)</i>
Challenges in evidence-based practice implementation	Inconsistencies in guideline dissemination	“I only found out about a major sepsis protocol change by overhearing a colleague” (B-ACP6) <i>No posters, guideline updates, or reminders observed in staff areas at Site B (Observation 31, CCU, Site B)</i> <i>Governance audit at Site B identified ‘no formal system to track staff awareness of updates’ (Document Analysis)</i> <i>Silence around updates at Site B striking compared to Site A’s structured communication routes. (Reflective Journal)</i>
		Peer discussions as a knowledge-integration strategy <i>“After a complex case, we sit down and talk about what worked and what didn’t” (A-NM3)</i> <i>Observed post-cardiac arrest debrief with multi-disciplinary</i>

Table 5 (continued)

Theme	Subtheme	Illustrative quotes
	Simulation-based learning and digital resources	<i>input (Observation 21, Site A, ICU)</i> <i>Staff debriefing guidance outlined as mandatory after critical incidents at Site A (Document Analysis)</i> <i>Debriefs a crucial, under-appreciated space where guidelines meet lived clinical reality (Reflective Journal)</i> <i>“We have monthly simulation drills - it helps bridge theory and reality” (A-ACP1)</i> <i>Observed high-fidelity simulation session on sepsis management (Observation 17, HDU, Site A)</i> <i>Simulation attendance logs mandatory for Site A ICU/HDU nurses; optional for Site B (Document Analysis)</i> <i>Sim sessions visibly boosted nurses’ confidence in adapting new guidelines on the ward (Reflective Journal)</i>

Booklet). Observations showed mentoring often depended on individual relationships and workload. A senior nurse coached a junior colleague using experiential tactics rather than guidelines (Observation 28, Site B, CCU). Reflective notes pointed out that peer support, while valuable, lacked consistency in high-pressure shifts.

These findings indicate the variability in mentorship structures and how it affects continuity and confidence in applying EBP.

3.1.3. Barriers to knowledge access

In both sites, time constraints and workload affected the ability to engage with formal knowledge sources. Night shifts were particularly challenging, with nurses citing limited opportunities to review new guidelines.

“Night shifts are tricky. We don’t have time to sit and review guidelines, so we rely on what we know from past experiences” (A-SN7).

Access to digital resources was also inconsistent. Site A provided online access to updated protocols via tablets and clinical workstations, enabling real-time reference. Site B, by contrast, had limited terminals and no structured access strategy. One nurse highlighted the implications:

“We don’t always get updates on new guidelines, so we just use what we already know. Sometimes you hear there’s been a change weeks after it’s happened” (B-SN6).

Observations confirmed that during emergencies, nurses bypassed digital tools in favour of intuition or past experience (Observation 29, Site B, ICU). This finding was reflected in a staff survey identifying “technology availability” as a barrier (Document Analysis - Site B Staff Survey). Reflective field notes from Site A acknowledged better access to structured resources but also identified similar constraints during peak workloads.

This highlights the structural barriers that persist even in relatively well-resourced units, reinforcing the need for targeted infrastructure and time protection to facilitate knowledge engagement.

3.2. Institutional and hierarchical influences on knowledge use

3.2.1. Organisational culture and decision-making

Organisational culture played a critical role in shaping knowledge

mobilisation. At Site A, nurses described an open environment that encouraged critical engagement with protocols and collaborative decision-making.

“We’re encouraged to speak up during rounds and ask questions if something feels off” (A-ACP3).

This inclusive culture was evident during MDT rounds, where nurses contributed to antibiotic decisions (Observation 9, Site A, ICU). Governance documents confirmed that interdisciplinary dialogue was a standard agenda item (Document Analysis).

In Site B, by contrast, hierarchical norms restricted such engagement.

“We’re expected to follow instructions, not question them. Even if a guideline doesn’t quite fit the situation, we just go with it” (B-SN7).

Observations of MDTs revealed a physician-led structure with minimal nursing input (Observation 12, Site B, CCU). Field notes captured staff hesitation to challenge decisions even when discrepancies between protocol and patient condition were evident.

3.2.2. Leadership support for knowledge use

Leadership engagement varied significantly across the two settings. In Site A, nurse managers played a visible role in disseminating knowledge and reinforcing EBP.

“Our nurse manager updates us regularly on policy changes and what it means for patient care” (A-NM1).

Pre-shift huddles facilitated direct discussions about protocol updates (Observation 14, Site A, HDU). Policy records documented this leadership function as a formal expectation (Document Analysis - Site A Policy Update Logs).

By contrast, Site B lacked a reliable mechanism for updates. An ACP noted the risks:

“Sometimes we find out about changes to protocols after they’ve already been in place for weeks. It depends who you’re working with” (B-ACP2).

A governance audit confirmed there was “no formal mechanism” to ensure awareness of updates (Document Analysis, Site B Audit Report). These disparities underscored how leadership behaviours shaped frontline knowledge access and team confidence in applying new evidence.

3.3. The role of experiential knowledge and clinical intuition

3.3.1. The use of intuition in clinical decision-making

Both sites highlighted the value of intuition, particularly in high acuity care where formal indicators may lag behind clinical judgment. Intuition was seen as a vital resource derived from experience and situational awareness.

“Sometimes, you just know when something isn’t right, even before the vitals change. It’s about reading the patient, not just the numbers” (A-SN5).

In Site A, an ACP recognised subtle signs of deterioration and intervened early despite normal scores (Observation 19, Site A). Yet, policy documents made no reference to intuition, emphasising compliance with formal metrics (Document Analysis, Site A Clinical Governance Manual).

In Site B, nurses often deferred intuition-based actions due to the need for physician confirmation.

“We have protocols for everything, but patients don’t always fit neatly into them. You have to wait for a doctor to sign off” (B-ACP4).

Such delays, though procedurally sound, were observed to impede timely care responses (Observation 24, Site B, CCU).

3.3.2. The influence of past experiences on knowledge use

Prior clinical encounters informed decision-making, especially when rapid judgment was required. Case memory served as an informal repository of knowledge that bridged guideline gaps.

“After a similar case last year, I knew exactly what to look for. It’s not something you learn in a book” (A-SN8).

During a sepsis case, a nurse recalled prior airway challenges and adapted care accordingly (Observation 25, Site A). However, structured opportunities for sharing experiential learning were rare. Site A’s training framework lacked reflective forums to formalise this knowledge (Document Analysis, Site A Education Strategy).

At Site B, similar reflections were evident, but institutional protocols constrained action.

“Here we always have to double-check before making changes. You can’t just go with your gut” (B-SN8).

Field notes recorded a nurse recognising early airway compromise but delaying action pending physician approval (Observation 29, Site B, HDU). These differences highlighted how organisational trust and autonomy influenced the integration of past experience into practice.

These findings reinforce that experiential knowledge remains a crucial but institutionally under-recognised component of clinical decision-making.

3.4. Challenges in evidence-based practice implementation

3.4.1. Time constraints and workload pressures

Time scarcity was one of the most cited barriers to EBP engagement. Nurses across both sites reported limited opportunity to access evidence during shifts.

“We’re expected to follow best practices, but realistically, when you have a full ward, there’s no time to sit down and look up the latest evidence” (A-ACP2).

At Site B, break rooms remained unused and no protected learning time was observed (Observation 16, Site B, CCU). Staff survey data identified workload as the primary obstacle to EBP training (Document Analysis - Site B Workforce Survey).

Even at Site A, where organisational supports were stronger, time pressures interfered with EBP.

“We just have to get through the night first... there’s no time for anything else” (Reflective Journal, Site A).

These site level disparities offer an important lens on how macro level EBP initiatives can falter without localised adaptation and leadership engagement.

3.4.2. Inconsistencies in guideline dissemination

Site B lacked a structured system to ensure that staff received updated protocols.

“I found out about a major change in sepsis management weeks after it had been implemented, just by overhearing a colleague” (B-ACP6).

No posters, emails, or briefings were observed during data collection (Observation 31, Site B). In contrast, Site A used laminated updates and mandatory sign-offs (Observation 22, Site A, ICU; Document Analysis, Site A Policy Logs).

Field reflections described Site B’s approach as “silent,” with changes depending on informal communication networks rather than standardised systems.

3.4.3. Resistance to change

Resistance to guideline adoption was present at both sites but more visible at Site B. This often manifested as non-compliance or reluctance to abandon established routines.

“Some nurses stick to what they’ve been doing for years, even when there’s new evidence suggesting a better approach” (A-SN4).

Observed during training at Site B, a nurse dismissed the need for a new wound care protocol (Observation 30, Site B, HDU). Education strategies in Site A acknowledged the need for leadership in promoting change, whereas Site B lacked guidance on this front (Document Analysis).

Field notes described passive resistance, where staff accepted updates during meetings but reverted to previous habits in practice.

3.5. Strategies for integrating knowledge into practice

3.5.1. Peer discussions as a knowledge integration strategy

Peer dialogue provided a flexible and trusted channel for refining practice. Post-incident debriefs were embedded in Site A routines and supported interprofessional learning.

“After a complex case, we sit down and talk about what worked and what didn’t. That’s where the real learning happens” (A-NM3).

One observed debrief after a cardiac arrest included joint reflection on EBP relevance (Observation 21, Site A, ICU). Site A’s policy mandated such sessions (Document Analysis - Site A Governance Policy).

In Site B, peer discussions occurred informally.

“You often hear about updates over coffee or during handover... it depends who you’re working with” (B-SN7).

While valued, this method lacked structure and consistency, increasing the risk of knowledge gaps.

3.5.2. Simulation-based learning and digital resources

Simulation was routine at Site A and widely seen as bridging theory and practice.

“We have monthly simulation drills. It helps bridge theory and reality” (A-ACP1).

Sessions were well-attended and linked to professional development (Observation 17, Site A; Document Analysis - Site A Training Compliance Log). By contrast, Site B’s simulation access was limited.

“We’re expected to know the latest protocols, but we don’t get enough practical training to apply them properly” (B-SN7).

Digital tools also varied. At Site A, bedside technology facilitated just-in-time learning, while Site B lacked immediate access.

“Seeing nurses quickly pull up the latest fluid management guidance mid-ward round was normalised at Site A” (Reflective Journal, Site A).

Collectively, these findings suggest that combining peer discussion, simulation, and digital resources can buffer structural barriers and enhance nurses’ capacity to engage with and apply evidence in clinical care.

4. Discussion

This study explored how critical care nurses engage with evidence and other forms of knowledge in high-pressure clinical environments. The findings contribute to a growing body of literature on EBP in nursing, offering both confirmation of known barriers and fresh insights into how these barriers are experienced and navigated in real-world practice.

4.1. Integrating formal and informal knowledge sources

The findings align with previous research showing that nurses do not

rely solely on formal guidelines but instead draw on a combination of written protocols, peer input, clinical experience, and intuition [49,50]. This blending of knowledge types is especially pronounced in critical care, where real-time decision-making often necessitates swift action that may preclude consulting written evidence. As found in similar studies [51,8], participants in this study often relied on case memory and intuition when facing rapidly evolving clinical scenarios.

What distinguishes the current findings is the depth of ethnographic detail illustrating how these knowledge sources are negotiated within different organisational cultures. In Site A, the availability of updated protocols, structured leadership engagement, and routine use of simulation and debriefing created an environment where formal and informal knowledge could be integrated more seamlessly. This supports previous work suggesting that organisational supports enhance EBP engagement [5,19]. In contrast, in Site B, knowledge transfer relied heavily on interpersonal relationships and informal communication, consistent with studies noting that EBP is undermined when access to guidelines is inconsistent or poorly communicated [51]. Unlike prior studies that broadly report barriers, this study unpacks how organisational routines and leadership styles concretely shape knowledge integration.

4.2. Professional role and knowledge engagement

Our findings offer new insights into how knowledge use differs across nursing roles. ACPs demonstrated a stronger sense of autonomy and were more likely to challenge protocols based on experiential knowledge, while SNs often described deferring to hierarchical authority even when their clinical judgement pointed to an alternative course of action. This aligns with research highlighting the differentiated capacity of nurses to act on knowledge depending on their level of authority and role clarity [52,53].

Nurse managers played a crucial role in reinforcing or inhibiting knowledge flow. Where they were visible, engaged, and proactive in disseminating evidence, as seen in Site A, staff reported higher confidence in applying guidelines. These findings are consistent with earlier research suggesting that transformational leadership is a key enabler of EBP [54,55]. In Site B, where leadership was perceived as inconsistent or absent, staff described greater uncertainty about new protocols and less confidence in acting on emerging evidence. This echoes work by Saunders and Vehviläinen-Julkunen [19], who observed that poor leadership visibility reduces frontline nurses’ capacity to engage with formal knowledge. These role-based insights extend current understandings of EBP adoption, offering a more differentiated view that can inform tailored implementation strategies by role.

4.3. Cultural attributes of practice

The cultural specificity of EBP engagement became especially visible through the ethnographic lens. In Site A, shared governance, open team communication, and routine feedback structures created what might be described as a learning-oriented culture. These features resonate with characteristics of high-performing healthcare teams described in the literature [56,18]. In contrast, Site B exhibited a more hierarchical and compliance-driven culture, in which deference to medical authority and rigid interpretations of policy limited the adaptive use of knowledge. This mirrors prior research suggesting that rigid hierarchies and risk-averse cultures can stifle innovation and reduce staff willingness to question outdated practices [12,14].

The ethnographic data also revealed that cultural norms shaped how knowledge was enacted beyond what guidelines or policies prescribed. For instance, despite protocols being available in Site B, the lack of structured dissemination and the cultural reluctance to question decisions made them less usable in practice. As Grimshaw et al. argue, EBP is not only a technical process but a social one, embedded in norms, values, and relationships [11]. The results support this claim by

illustrating how cultural context mediates whether evidence is taken up or set aside. This cultural framing provides a more nuanced understanding of EBP as a situated practice rather than a set of technical behaviours, offering novel implications for how policy and training are shaped.

4.4. Barriers to evidence-based practice

Our findings highlight how institutional and temporal constraints shape how and when nurses can engage with formal evidence. Findings confirmed well-documented barriers to EBP, including time constraints, workload, and poor access to digital or physical resources [5,19]. However, the ethnographic data add important detail to these themes. For example, time pressure was not simply about shift length or patient load but about how time was structured. At Site A, protected spaces such as simulation sessions and huddles carved out room for knowledge-sharing, even under pressure. In Site B, the absence of such structures meant that EBP engagement was constantly deprioritised.

Resistance to change also emerged, particularly among experienced nurses who felt that new protocols disrupted established routines. This is consistent with previous findings that staff may resist change if they perceive it as imposed rather than co-developed [57,58]. In Site A, leadership strategies helped mitigate this resistance through clear communication and participatory implementation, echoing research on the importance of co-design and shared decision-making in EBP rollouts [6].

4.5. Strategies for supporting knowledge integration

The study highlighted several effective strategies for supporting knowledge integration. Peer discussions and informal debriefs, especially after critical incidents, served as key moments of reflective learning. This finding aligns with evidence that team-based reflection improves both learning and patient safety [59,60]. In Site A, the routine use of simulation-based learning provided structured opportunities to apply and consolidate new knowledge, an approach supported in literature as highly effective for critical care settings [61,62].

Digital tools were also recognised as facilitators of real-time knowledge use, but only where access was immediate and normalised. This supports findings by Greenhalgh et al. [63–65], who advocate for just-in-time access to evidence through integrated digital platforms. However, in Site B, limited terminal access and informal dissemination structures meant that digital tools were underutilised. The contrast between sites reinforces the idea that technology alone does not guarantee EBP unless supported by training, workflow integration, and leadership buy-in [66–68]. These strategies, while modest, illustrate how small structural shifts can help translate national EBP priorities into local, actionable practices [69].

5. Strengths and limitations

This study offers a detailed insight into how critical care nurses engage with evidence and informal knowledge in high-pressure settings. A key strength lies in the use of focused ethnography across two contrasting sites, which allowed for direct comparison of organisational influences on EBP. The triangulation of interviews, observations, and document analysis gave depth to the data and strengthened the validity of findings.

Another strength was the inclusion of a range of nursing roles. Involving SNs, NMs, and ACPs allows the study to capture variations in knowledge use across professional boundaries. These differences are rarely explored in-depth in EBP literature and add an important layer of understanding.

However, there are limitations. The research was limited to two sites in one region of England, which may affect transferability. The majority of participants were experienced nurses, so the views of less experienced

or international staff with limited English proficiency may be under-represented.

Although prolonged observation helped reduce reactivity, it is possible that some behaviours were influenced by the presence of a researcher. Additionally, the study did not measure the direct impact of knowledge practices on patient outcomes, which would be valuable in future work.

6. Implications for research and practice

These findings suggest that enhancing EBP in critical care requires more than simply updating guidelines or providing access to evidence. Cultural, relational, and structural conditions must also be addressed. Investments in leadership development, structured mentorship, and protected learning time may help bridge the evidence-practice gap.

Future research should explore how different models of nurse education and clinical supervision influence knowledge mobilisation, particularly in settings where traditional hierarchies remain strong. Comparative ethnographic studies across more diverse institutional contexts could further illuminate how organisational cultures either facilitate or constrain evidence use.

Finally, professional development initiatives should explicitly address the role of informal knowledge, such as intuition and experiential memory, and help staff integrate these with formal evidence in safe and accountable ways. Acknowledging and legitimising these forms of knowledge can support more holistic and responsive models of EBP in acute care.

7. Conclusion

This study examined how critical care nurses engage with evidence and clinical knowledge in two hospital settings with contrasting organisational cultures. The findings suggest that evidence-based practice is most effective when formal systems, such as clear guideline dissemination, simulation-based training, and strong clinical leadership, work in tandem with informal sources of knowledge like peer learning and clinical experience.

What emerged from the data was not a lack of willingness to engage with evidence, but rather a set of organisational conditions that shaped whether, when, and how that engagement occurred. Nurses did not separate evidence from experience; they combined both in ways that were often pragmatic and context-dependent. In units where leadership was visible, where discussion was encouraged, and where education was embedded in everyday routines, nurses reported greater confidence in using evidence to inform care.

These findings indicate that improving the uptake of evidence-based practice requires more than individual training. Structural support, protected time for reflection, and leadership that actively values knowledge sharing are all necessary conditions. Without these, even the most motivated practitioners will struggle to engage with evidence meaningfully.

Ultimately, this study highlights the importance of thinking relationally about knowledge use in nursing. Evidence matters, but how that evidence is taken up depends on the relationships, routines, and resources that surround the clinical encounter. Strengthening these foundations will be key to sustaining evidence-based practice in high-pressure environments like critical care.

Ethical approval

The study was conducted in accordance with the guidelines of the Declaration of Helsinki and was approved by the University of Research Ethical Approval System (Reference ID: UoB/00,184), ensuring compliance with UK national regulations. Approval was also obtained from the Research & Development Unit of the hospitals involved in the study, ensuring compliance with institutional governance protocols.

Consent to participate

Informed consent to participate was obtained from all participants prior to their enrolment in this study. Participant information sheets and consent forms were provided in advance via email. These documents were then reviewed and verbally confirmed at the start of each observation episode and interview recording.

Data availability

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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CRediT authorship contribution statement

Jude Ominyi: Writing – review & editing, Resources, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Ukpai Eze:** Writing – review & editing, Formal analysis. **Adewale Alabi:** Writing – review & editing, Methodology. **Aaron Nwedu:** Writing – review & editing, Formal analysis.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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