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Research Utilization and Its Associated Factors among Healthcare Professionals in a Hospital Setting: A Cross-Sectional Study

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ABSTRACT

The utilization of research findings in healthcare practice is essential for improving service quality; however, its extent and associated factors vary. This study aimed to assess research utilization and its demographic, individual, and organizational correlates among healthcare professionals. This descriptive-analytical cross-sectional study was conducted among 269 healthcare professionals at Dr. Gharazi Hospital, Malayer, Iran, during the first half of 2026. Data were collected using a researcher-developed questionnaire assessing research knowledge, access to scientific resources, practical research use, individual barriers, organizational support and culture, workload and environmental conditions, and research utilization outcomes. Descriptive statistics, Spearman's correlation, Mann–Whitney U, and Kruskal–Wallis tests were applied. Participants had a mean age of 36.5±7.6 years, and 56.6% were women. The mean outcome score, operationalized as healthcare service quality, was 4.29±0.68. Practical research use (ρ=0.245, P<0.001) and organizational support and culture (ρ=0.149, P=0.015) were positively associated with the outcome, whereas individual barriers showed a negative association (ρ=−0.321, P<0.001). Research knowledge (ρ=0.030, P=0.627), resource access (ρ=−0.090, P=0.147), and workload and environmental conditions (ρ=0.071, P=0.251) showed no significant associations. Gender was the only demographic or occupational characteristic significantly associated with the outcome (U=7653.5, P=0.049). Research utilization was associated with practical research use, organizational support and culture, and individual barriers. Promoting evidence-based clinical and managerial decision-making, strengthening organizational support, and addressing individual barriers may improve research utilization and healthcare service quality.

Keywords: Research utilization, Healthcare professionals, Evidence-based practice, Organizational support, Research barriers, Healthcare quality

Introduction

Scientific research is one of the fundamental pillars of knowledge development, improvement of organizational performance, and enhancement of the quality of health services. In contemporary healthcare systems, the increasing complexity of clinical and managerial issues and the need for accurate, evidence-based decision-making have further increased the importance of using research findings [1, 2].

However, the production of scientific knowledge alone cannot lead to improved performance, and the gap between generated knowledge and knowledge in use remains a major challenge in decision-making systems and health services [3, 4]. Therefore, the effective transfer of knowledge from research settings to practice and the transformation of scientific evidence into practical decisions and actions constitute an important component of improving the quality of healthcare systems. In this context, the concept of Research Utilization refers to the purposeful, conscious, and systematic use of research findings in practical situations [5].

Research utilization strengthens the connection between knowledge production in academic settings and its use in real-world environments, enabling scientific findings to move beyond knowledge generation and be incorporated into professional decision-making and actions [6, 7].

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In healthcare, this concept refers to the conscious and judicious use of research evidence in clinical, care, and managerial processes and can contribute to improving the effectiveness of decisions, increasing efficiency, and promoting the appropriate use of resources [5, 8]. Furthermore, continuous interaction among researchers, managers, and professional staff can foster a research-oriented culture and strengthen the use of evidence in healthcare organizations [9].

The utilization of research findings in clinical settings is particularly important because treatment and care decisions are directly related to patients' health and safety. The use of scientific evidence in clinical decision-making can contribute to the selection of more effective, safer, and cost-effective treatment and care approaches [10, 11]. Available evidence also indicates that the effective use of research can contribute to improving patient health outcomes, reducing medical errors, and enhancing the quality of healthcare services [12]. Hospitals that have strengthened a culture of using scientific evidence within their organizational structures have greater capacity to improve service quality and professional performance [13, 14]. In addition, the use of research findings can enhance healthcare professionals' knowledge, increase their confidence in decision-making, and strengthen their professional performance [9]. Therefore, research utilization can be considered an important component of the movement of healthcare systems toward evidence-based decision-making.

Despite this importance, available evidence indicates that a considerable gap exists between the production of scientific evidence and its actual use in clinical settings, a problem referred to as the knowledge-practice gap [15, 16]. Healthcare professionals, including physicians and nurses, may face multiple barriers to using research findings in their routine decision-making, despite having access to research evidence. Lack of time, high workload, limited access to scientific resources, inadequate research and analytical skills, and insufficient organizational support or resistance to change are among the barriers that can constrain the process of translating evidence into practice [17, 18].

Under such circumstances, clinical decisions may continue to be influenced by individual experience, professional habits, and existing practices, and the potential of research to improve performance may not be fully utilized [19].

Studies conducted in Iran have also confirmed the existence of these challenges. Weak organizational learning cultures, inadequate managerial support, and limited access to information databases and scientific resources have been reported as barriers to research utilization in Iranian studies [20, 21]. In addition, insufficient training in critical appraisal of evidence, interpretation of research findings, and the skills required to use scientific evidence can limit healthcare professionals' ability to translate knowledge into clinical practice [22]. Conversely, managerial support, training in the required skills, easier access to scientific articles and resources, and the development of organizational policies and structures that support the use of evidence can facilitate research utilization [23, 24]. Therefore, research utilization cannot be attributed solely to the individual characteristics of healthcare professionals; rather, it is influenced by a combination of individual, organizational, and environmental factors.

Ineffective utilization of research findings in healthcare settings can have important consequences for the quality and efficiency of health services. When clinical decisions are not sufficiently based on up-to-date scientific evidence, the likelihood of using ineffective approaches and the occurrence of medical errors may increase [25, 26]. Failure to use research findings may also be associated with increased healthcare costs, duplication of services, and the use of suboptimal practices [27]. Continued reliance on traditional or experience-based practices without adequate consideration of new evidence may also affect the quality of care and patient satisfaction [5]. Furthermore, inadequate implementation of evidence can result in the waste of human and economic resources and further deepen the gap between research and practice [3, 28, 29]. Consequently, strengthening research utilization is essential not only for making better use of investments in research but also for improving the quality and safety of healthcare services.

The factors influencing research utilization can be examined across different dimensions. At the individual level, healthcare professionals' knowledge and awareness of scientific evidence, their ability to understand and appraise research findings, research skills, attitudes toward the use of evidence, and barriers such as lack of time and resistance to change are important. At the organizational level, managerial support, organizational culture, the availability of scientific resources and facilities, and working conditions can influence the extent to which research is utilized.

In addition, access to scientific resources and the quality and applicability of research findings are important factors associated with the translation of knowledge into practice. From this perspective, research utilization results from the interaction between individual characteristics of healthcare professionals and organizational and environmental conditions; therefore, simultaneous assessment of these factors is necessary to understand the existing situation.

This issue is particularly important in healthcare settings in Iran because resource limitations, increasing healthcare costs, and the need to improve service quality have increased the need for evidence-based decision-making. Failure to use scientific evidence can lead to reduced quality of care, increased hospital costs, and decreased efficiency of the healthcare system [30, 31].

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Furthermore, neglecting research findings may reduce healthcare professionals' motivation to update their professional knowledge and skills and increase the gap between academia and clinical practice [16, 32]. Therefore, identifying the status of research utilization and its associated factors in healthcare settings can provide valuable information for health managers and planners to design more appropriate educational and organizational interventions to strengthen the use of evidence[28, 33].

Despite existing studies on the barriers to and facilitators of research utilization, the status of this process may vary across hospitals depending on organizational structure, working conditions, workforce composition, and the level of support for research activities. Dr. Gharazi Hospital in Malayer is affiliated with the Social Security Organization, and conducting research is not directly included among the organizational responsibilities of its healthcare staff. Therefore, examining the extent to which research findings are used and the factors associated with their utilization in this setting can provide a picture of the current situation and create a basis for identifying areas for improvement. Such an assessment can be used to inform planning aimed at increasing access to evidence, strengthening organizational support, and improving the use of research findings in clinical and managerial decision-making.

Therefore, the present study was conducted to determine the extent of research utilization and to investigate the factors associated with it among healthcare staff at Dr. Gharazi Hospital in Malayer.

Methods

Study design and setting

This descriptive-analytical cross-sectional study was conducted to assess research utilization and its associated factors among healthcare professionals at Dr. Gharazi Hospital in Malayer, Iran. The study was conducted during the first six months of 2026 [1405 in the Iranian calendar]. Study population and sampling

The study population consisted of healthcare professionals working at Dr. Gharazi Hospital in Malayer. Because the target population was limited in size, a census sampling approach was used. All 269 eligible healthcare professionals were invited to participate in the study. The study population included healthcare professionals from different occupational and clinical units, including physicians, nurses, midwives, operating room personnel, laboratory personnel, and radiology personnel.

Eligibility criteria

The inclusion criteria were employment as a healthcare professional at Dr. Gharazi Hospital, at least six months of work experience, willingness to participate in the study, and the ability to complete the questionnaire. Participants were excluded if they did not complete the questionnaire or were unavailable during the data-collection period because of leave or work-related mission. Non-clinical staff were also excluded from the study.

Study instrument

Data were collected using a researcher-developed questionnaire designed to assess research utilization and factors associated with its use among healthcare professionals. The questionnaire was developed based on the theoretical literature on research utilization and knowledge translation, the objectives of the study, and relevant previous research. The development of the questionnaire was informed by the Knowledge-to-Action [KTA] and Promoting Action on Research Implementation in Health Services [PARIHS] frameworks. In addition, relevant domains from the BARRIERS Scale, instruments addressing knowledge utilization, and measures related to evidence-based practice were considered in developing and adapting the questionnaire items. Findings from relevant Iranian studies were also used to ensure contextual appropriateness of the instrument.

The questionnaire assessed six explanatory constructs: awareness and knowledge of research findings; access to scientific resources; practical use of research findings in clinical and managerial decision-making; individual barriers to research utilization; organizational support and organizational culture; and workload and environmental conditions. The questionnaire also included a measure of the outcome of research utilization, operationalized as perceived quality of healthcare services. All questionnaire items were scored using a five-point Likert-type scale. Scores for each construct were calculated based on the corresponding items, with higher scores indicating higher levels of the respective construct.

Validity and reliability

Content validity was assessed by 10 experts with academic and professional expertise relevant to the study. The experts evaluated the necessity, relevance, clarity, and simplicity of the questionnaire items. The Content Validity Ratio [CVR] and Content Validity Index [CVI] were calculated. Based on the content-validity assessment and expert feedback, two items [Q4_4 and Q6_3] were removed and the questionnaire was subsequently revised.

Construct validity was assessed using exploratory and confirmatory factor analyses. Exploratory factor analysis was conducted on a subsample of 100 participants using principal component analysis [PCA] with Varimax rotation. Confirmatory factor analysis was subsequently performed on the remaining 169 participants using AMOS version 24 to evaluate the factor structure of the instrument. The reliability of the questionnaire was assessed using internal consistency and test–retest reliability. A preliminary assessment was conducted among 30 participants.

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Internal consistency was evaluated using Cronbach's alpha, and test–retest reliability was assessed using the infraclass correlation coefficient [ICC]. Cronbach's alpha coefficients for the study dimensions ranged from 0.724 to 0.919, indicating acceptable to excellent internal consistency.

Data collection

Following the necessary administrative permissions, eligible healthcare professionals were invited to participate in the study. The purpose of the study, voluntary nature of participation, and confidentiality of the collected information were explained to the participants before questionnaire completion.

The finalized questionnaires were distributed to eligible participants and completed by them. Completed questionnaires were reviewed for completeness before data entry and statistical analysis. Participation was voluntary, and no personally identifying information was included in the analytical dataset.

Statistical analysis

Data were analyzed using SPSS version 26. Descriptive statistics, including frequency, percentage, mean, and standard deviation, were used to summarize participants' demographic and occupational characteristics and the study variables. Skewness and kurtosis were also examined to describe the distribution of the quantitative variables. The distribution of the main quantitative variables was assessed using the Kolmogorov–Smirnov test. The results indicated significant departures from normality [$P < 0.05$]; therefore, non-parametric statistical methods were used for inferential analyses.

The relationships between the research-utilization outcome and the explanatory variables were assessed using Spearman's rank correlation coefficient [ϱ]. Spearman correlation was used to examine the relationships between perceived quality of healthcare services and awareness and knowledge, access to scientific resources, practical use of research findings, individual barriers, organizational support and culture, and workload and environmental conditions.

For comparisons of the research-utilization outcome across categorical demographic and occupational characteristics, the Mann–Whitney U test was used for variables with two categories, whereas the Kruskal–Wallis test was used for variables with more than two categories. The relationship between age and the research-utilization outcome was examined using Spearman's rank correlation coefficient. All statistical tests were two-sided, and a P value < 0.05 was considered statistically significant.

Ethical considerations

Participation in the study was voluntary. Participants were informed about the purpose of the study and the procedures for completing the questionnaire and were assured that their participation was voluntary and that they could withdraw from the study without consequences. The confidentiality of participants' information was maintained throughout data collection, analysis, and reporting. No personally identifying information was reported, and the collected data were used solely for research purposes. The study was conducted after obtaining the required permission from the relevant institutional authorities and approval from the appropriate research ethics committee.

Results

Demographic Characteristics of the Study Sample

The results of Table 1 showed that the majority of the sample were women [56.6%], and the majority of respondents had a bachelor's degree [62.8%]. The largest occupational and work-unit groups were nursing, and the majority of participants had 10–20 years of work experience [37.9%]. The mean [standard deviation] age of the participants was 36.5 [7.6] years.

Table 1. Frequency distribution of the respondents' demographic characteristics

Variable	Characteristics	Number	Percentage
Gender	Female	152	56.6
	Male	117	43.5
Educational level	Diploma	0	0
	Associate degree	2	0.7
	Bachelor's degree	169	62.8
	Master's degree	18	6.7
	Doctoral degree	31	11.5
	Specialty/Subspecialty	49	18.2
Occupation	Physician	76	28.3
	Nurse	119	44.2
	Midwife	17	6.3
	Laboratory technician	12	4.5
	Operating room technician	18	6.7
	Other	27	10.0
Work experience	Less than 5 years	64	23.8
	5–10 years	50	18.6
	10–20 years	102	37.9
	More than 20 years	53	19.7
Work unit	Operating room	18	6.7
	Laboratory	12	4.5
	Anesthesia	11	4.1
	Nursing	119	44.2
	Physician	76	28.3
	Equipment	2	0.7
	Nutrition	1	0.4
	Pharmacy	2	0.7
	Radiology	11	4.1
	Midwifery	17	6.3
Age	Mean	36.5	—
	Standard deviation	7.6	—

Factors Associated with the Level of Research Utilization

The results of Table 2 showed that quality of healthcare services, as an outcome of research utilization, had the highest mean among the variables examined [mean = 4.29, standard deviation = 0.68]. This was followed by the practical use of research findings by personnel in clinical and managerial decision-making [mean = 3.81, standard deviation = 0.73] and workload and environmental conditions of healthcare personnel in the process of research utilization [mean = 3.80, standard deviation = 0.95].

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The mean level of awareness and knowledge of healthcare personnel regarding scientific research findings relevant to their field of work was 3.34 [standard deviation = 0.95]. In addition, the mean score for individual barriers to the utilization of research findings was 3.04 [standard deviation = 0.92], while the mean score for organizational support and culture in increasing research use was 2.96 [standard deviation = 0.94]. Access to scientific resources, databases, and research articles, with a mean of 2.67 [standard deviation = 0.93], had the lowest mean among the variables examined.

In terms of dispersion, quality of healthcare services had the lowest standard deviation among the variables examined [0.68], whereas awareness and knowledge of healthcare personnel and workload and environmental conditions of healthcare personnel both had the highest level of dispersion, with a standard deviation of 0.95.

Table 2. Description of factors associated with the level of research utilization

Variable	Mean	SD	Skewness	Kurtosis
Awareness and knowledge of healthcare personnel regarding scientific research findings relevant to their field of work	3.34	0.95	−0.95	−0.04
Access of personnel to scientific resources, databases, and research articles	2.67	0.93	−0.14	−0.57
Practical use of research findings by personnel in clinical and managerial decision-making	3.81	0.73	−0.72	1.17
Individual barriers to the utilization of research findings	3.04	0.92	0.01	−0.86
Organizational support and culture in increasing research use	2.96	0.94	−0.64	−0.61
Workload and environmental conditions of healthcare personnel in the process of research utilization	3.80	0.95	−0.52	−0.51
Quality of healthcare services [outcome of research utilization]	4.29	0.68	−1.69	5.09

Relationships with the Outcome of Research Utilization

The results of the analysis of the relationship between demographic characteristics and the outcome of research utilization are presented in Table 3. The results of Table 3 showed that, among the demographic characteristics examined, gender was the only demographic characteristic that showed a statistically significant difference in the outcome of research utilization [Mann–Whitney U test, U = 7653.5, P = 0.049]. In contrast, differences in the outcome of research utilization according to educational level [Kruskal–Wallis test, H = 7.41, P = 0.116], occupation [H = 10.38, P = 0.055], work experience [H = 6.65, P = 0.084], and work unit [H = 2.86, P = 0.678] were not statistically significant. Furthermore, no statistically significant relationship was observed between age and the outcome of research utilization [ϱ = 0.073, P = 0.233]. Therefore, among the demographic characteristics examined, only gender showed a statistically significant association with the outcome of research utilization.

Table 3. Relationship between demographic characteristics and the outcome of research utilization

Demographic variable	Test statistic	P-value
Gender	7653.5	*0.049
Educational level	7.41	**0.116
Occupation	10.38	**0.055
Work experience	6.65	**0.084
Work unit	2.86	**0.678
Age	ϱ = 0.073	0.233

Table 4. Correlations between factors associated with research utilization and the outcome of research utilization

Factor	Outcome of research utilization [quality of healthcare services]	P-value
Awareness and knowledge of healthcare personnel	0.030	0.627
Access of personnel to scientific resources	−0.090	0.147
Practical use of research findings by personnel in clinical and managerial decision-making	0.245	<0.001
Individual barriers	−0.321	<0.001
Organizational support and culture	0.149	0.015
Workload and hospital environmental conditions	0.071	0.251

Table 4 presents the correlations between factors associated with research utilization and the outcome of research utilization. The results of Table 4 showed that there was no statistically significant relationship between awareness and knowledge of healthcare personnel and the outcome of research utilization [ϱ = 0.030, P = 0.627]. Similarly, the relationship between access of personnel to scientific resources and the outcome of research utilization was not statistically significant [ϱ = −0.090, P = 0.147].

In contrast, a positive and statistically significant relationship was observed between the practical use of research findings by personnel in clinical and managerial decision-making and the outcome of research utilization [ϱ = 0.245, P < 0.001]. Furthermore, a negative and statistically significant relationship was found between individual barriers and the outcome of research utilization [ϱ = −0.321, P < 0.001]. Organizational support and culture also showed a positive and statistically significant relationship with the outcome of research utilization [ϱ = 0.149, P = 0.015].

In contrast, no statistically significant relationship was observed between workload and hospital environmental conditions and the outcome of research utilization [ϱ = 0.071, P = 0.251]. Overall, among the factors examined, practical use of research findings and organizational support and culture had positive and statistically significant relationships with the outcome of research utilization, whereas individual barriers showed a negative and statistically significant relationship with this outcome.

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Discussion

The findings of the present study showed that the level of awareness and knowledge of healthcare personnel regarding scientific research findings relevant to their field of work was above average and relatively favorable. This finding indicates that the studied personnel are not unfamiliar with the importance of updating their knowledge and research findings and have an appropriate capacity to use scientific evidence. This result is consistent with studies that have identified research awareness and knowledge as factors influencing the use of evidence in clinical settings. Ståhl et al. identified limited awareness of research findings and unfamiliarity with how to access and interpret them as barriers to evidence use [34], while Aynalem et al. confirmed the role of nurses' knowledge and awareness in the use of clinical evidence [35]. In the study by Chehrzad et al. insufficient awareness of research and inadequate skills related to the use of evidence were also reported as important barriers to research utilization. However, a favorable level of awareness in the present study does not necessarily imply the translation of knowledge into practice, as findings related to factors influencing research utilization showed that organizational and environmental constraints may hinder the conversion of this knowledge capacity into professional behavior [36].

In contrast, the personnel's access to scientific resources, databases, and research articles was not in a favorable condition. This finding is consistent with the studies by Mitro et al., Poiroux et al. and Avwerhota et al. which reported limited access to resources and information infrastructures as important barriers to the use of research evidence in clinical settings [37, 38]. In the study by Zareivenovel et al. inadequate information infrastructures and limited access to research resources were also identified as important barriers to the use of scientific knowledge in the health system.

Inadequate access may reduce personnel's opportunities to become familiar with new evidence and use it; however, the absence of a significant relationship between access to scientific resources and research utilization in the present study indicates that access alone is insufficient for integrating research into clinical processes. It appears that factors such as time, managerial support, organizational culture, and the existence of specific mechanisms for translating evidence into operational guidelines may play a more decisive role in this process [5].

One of the important findings of the present study was the high level of practical use of research findings in clinical and managerial decision-making. This finding indicates that, at least at the level of professional decision-making, personnel use research findings to a considerable extent to guide their actions. This result is comparable with the studies by Poiroux et al., Mitro et al. and Chehrzad et al. which emphasized the role of individual and organizational conditions in the use of evidence [39-41]. In addition, the studies by Tourani et al. and Saber Mahani et al. emphasized the importance of interaction between knowledge producers and users and the establishment of appropriate mechanisms for transferring knowledge into decision-making processes [42, 43].

However, individual barriers were reported at a moderate level. Lack of time, limited skills in analyzing and evaluating research, individual motivation, and difficulties in using research published in English may be among the factors that make the process of using evidence difficult despite personnel's adequate awareness. This finding is consistent with the results of Poiroux et al., Mitro et al. and Chehrzad et al. These studies also reported lack of time, inadequate research and analytical skills, and the gap between research and practical needs as important barriers to research utilization [37, 40, 41]. Therefore, simply increasing personnel's theoretical knowledge is probably insufficient to improve research utilization, and strengthening skills in searching for, critically appraising, and interpreting research findings, together with providing sufficient time for scientific activities, appears necessary.

On the other hand, the findings showed that organizational support and culture were at a low level in terms of promoting the use of research. This finding is consistent with the results of Mitro et al. who identified lack of managerial support, inadequate resources, and weak research-oriented organizational culture as important barriers to the use of evidence in clinical settings [40]. In domestic studies, Tourani et al. and Saber Mahani et al. also emphasized the need to establish supportive mechanisms and incentive policies and to strengthen organizational structures for knowledge translation and evidence use [44, 45]. Therefore, even when personnel possess adequate knowledge and have relative access to resources, weak organizational support can prevent the institutionalization of research utilization within the hospital setting. Establishing dedicated time for scientific activities, managerial support for implementing evidence-based changes, updating protocols, and establishing mechanisms such as scientific meetings and journal clubs may help strengthen this dimension. Another finding of the study showed that workload and environmental conditions were important challenges for personnel in the process of research utilization, while, in the relational analysis, this variable showed a positive relationship with attention to research. The first part of this finding is consistent with the results of Poiroux et al., Mitro et al. and Chehrzad et al. as these studies identified workload, time constraints, and unfavorable environmental conditions as barriers to the use of scientific evidence [37, 40, 41]. However, the positive relationship observed in the present study differs from some of these studies.

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This difference may be attributable to the characteristics of the study population, the organizational conditions of the hospital, the way workload is managed, and the extent of available support for evidence-based decision-making. One possible explanation is that in busy and complex environments, the increased need for rapid and accurate decision-making may encourage personnel to make greater use of guidelines, protocols, and scientific evidence. Therefore, workload may simultaneously function as an operational barrier and, when an appropriate context exists, as a stimulus for greater attention to evidence.

Another important finding was the absence of a significant relationship between personnel's demographic characteristics, including age, work experience, educational degree, and occupational position, and the level of research utilization. This result is not consistent with the findings of Ståhl et al. and Aynalem et al. who identified education and formal training as influential factors in research use [34, 35].

The observed difference may indicate that, in the studied hospital, organizational and work-environment conditions exert such a strong influence on personnel behavior that individual and educational differences do not result in significant differences in research utilization. From this perspective, managerial interventions and improvement of organizational infrastructures may be more important than focusing solely on individual characteristics of personnel.

In examining the relationships between the main variables, awareness and knowledge, as well as access to scientific resources, were not significantly associated with research utilization. This finding differs from the results of Aynalem et al. and Ståhl et al. which emphasized the role of knowledge, training, and access to resources in evidence use [34, 35]. At the same time, the findings of Mitro et al. indicate that even when awareness and willingness to use research are present, limitations such as time constraints, workload, and organizational support may prevent practical use [40]. Therefore, the present finding emphasizes that knowledge and access are necessary but probably insufficient conditions for achieving research utilization, and translating knowledge into practice requires an appropriate organizational and operational context.

In contrast, the practical use of research findings in clinical and managerial decision-making was significantly associated with the level of research utilization. This finding is consistent with the results of Zhu et al., Avwerhota et al. and Mitro et al. which emphasized the importance of translating research knowledge into practical decisions and actions [40, 46, 47]. Similarly, the studies by Tourani et al. and Saber Mahani et al. emphasized the role of interaction between knowledge producers and users in transferring evidence into decision-making processes [44, 45]. This finding is also conceptually expected, because the ultimate point of research utilization is achieved when scientific findings are incorporated into the selection of treatment and care methods, modification of protocols, managerial decisions, and other professional actions. Therefore, strengthening mechanisms for translating evidence into guidelines and operational decisions may play an important role in increasing research utilization.

Furthermore, individual barriers were negatively associated with research utilization; that is, an increase in barriers such as lack of time, inadequate skills in research appraisal, low motivation, and difficulty in linking research findings to the actual needs of the clinical environment was associated with lower research utilization. This finding is consistent with the results of Avwerhota et al., Poiroux et al. and Mitro et al. [39, 40, 47].

In contrast, organizational support and culture were positively associated with research utilization, which is consistent with the findings of Mitro et al. and Zhu et al. as well as the results of Tourani et al. and Saber Mahani et al. Taken together, these findings indicate that research utilization in the hospital is not merely an individual behavior but rather results from the interaction between personnel capabilities and organizational structure, culture, and support [40, 44-46].

Overall, the findings of the present study indicate that the main challenge to research utilization at Dr. Gharazi Hospital in Malayer is not merely a lack of knowledge or access to information, but rather the process of translating existing knowledge and evidence into professional practice. Although personnel had relatively favorable awareness and the practical use of research findings was also reported to be high, weak organizational support and culture, individual barriers, and working conditions may prevent this process from becoming institutionalized.

Therefore, to improve research utilization, interventions should focus not only on education and enhancing research literacy but also on strengthening managerial support, establishing organizational mechanisms for evidence-based decision-making, improving access to scientific resources, allocating time for scientific activities, and facilitating the translation of research findings into operational protocols and guidelines. Such an approach can help reduce the gap between knowledge and practice and strengthen a culture of evidence-based decision-making in the hospital setting.

Conclusion

Overall, the findings of this study showed that research utilization at Dr. Gharazi Hospital in Malayer is a multidimensional phenomenon that cannot be explained solely by the individual characteristics of healthcare personnel. Although the personnel demonstrated a relatively favorable level of research awareness and knowledge.

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Thus the level of practical use of research findings in clinical and managerial decision-making was also reported to be high, limited access to scientific resources, individual barriers, workload and environmental conditions, and particularly weak organizational support and culture remain important challenges to the institutionalization of evidence use. Furthermore, the absence of significant relationships between research awareness and knowledge, as well as access to scientific resources, and research utilization indicated that possessing knowledge and having access to evidence alone are insufficient to translate research into practice. In contrast, the significant relationship between the practical use of research findings and research utilization, together with the positive role of organizational support and culture, highlights the importance of establishing organizational and operational conditions for knowledge translation into practice.

Accordingly, improving research utilization in hospital settings requires a multilevel approach that goes beyond educating personnel and increasing their awareness. Ensuring sustained and easy access to scientific resources, strengthening skills in searching for and critically appraising evidence, allocating dedicated time for scientific activities, reducing environmental barriers, providing active managerial support for evidence-based decision-making, and establishing mechanisms for translating research findings into operational protocols and guidelines may facilitate more sustained use of evidence. Ultimately, strengthening an evidence-based organizational culture and linking research findings to actual clinical and managerial decision-making processes can help reduce the knowledge–practice gap and promote more effective use of research capacity to improve the quality of healthcare services.

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