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The Impact of Knowledge Creation, Acquisition, and Capture on Knowledge Sharing: An Investigation Among Nursing Professionals

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ABSTRACT

This study aims to inspect the effect of knowledge creation, acquisition, and capture, on knowledge sharing among nursing professionals. This empirical study is based on the survey method and data collected using a questionnaire tool. The study used a simple random sampling technique for collecting data. The study's findings showed that knowledge creation, knowledge acquisition, and knowledge capture, demonstrated a positive correlation with knowledge sharing. Although this study focuses on nursing professionals, the findings can be applied to other knowledge-concentrated organisations. The results of this study direct institutions to capitalise on the management process, and more precisely, on knowledge sharing among nursing professionals.

Keywords: Knowledge management; Nursing professionals; Knowledge creation; Knowledge acquisition; Knowledge capturing; Knowledge sharing

1. INTRODUCTION

Knowledge may be defined as an aptitude for practical application, an awareness of individuals and situations, or a comprehension of facts. This understanding of facts referred to as propositional knowledge, is typically described as a true belief that is differentiated from mere opinion or conjecture through the presence of justification. Knowledge Creation (KCR) in nursing professionals encompasses creating and modifying knowledge to effectively address clinical scenarios[1]. Nursing knowledge creation involves tailoring it to local contexts and utilising an integrated knowledge translation approach, leveraging pragmatic philosophy for practical application[2]. In the health sciences, Knowledge Acquisition (KAC) includes research, clinical practice, and patient data; however, theoretical knowledge is acquired by nursing professionals through classroom teaching and hands-on training[3]. Clinical trials and medical research provide instructors and students with empirical information in the nursing sector[4]. In the health sciences, Knowledge Capture (KCA) refers to the organised data collecting, assembling, classification, and archiving process with the purpose of advancing research, improving patient care, and making accurate decisions[5]. Electronic health records, systematic reviews, and meta-analyses6, as well as the preservation of important findings from research, clinical experiences, and patient information, all greatly enhance health outcomes. Knowledge Sharing (KSH) in nursing comprises skill transfer across specialties, units, and departments[7], enhancing care quality, collaboration, innovation, clinical decision-making[8], knowledge growth, accountability[9] and teamwork[10]. In the healthcare industry, the knowledge management process is essential for improving patient safety, quality of treatment, and satisfaction. As a result, the researchers want to find out how knowledge generation, acquisition, and capture affect information sharing in the Indian nursing professionals.

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2. LITERATURE REVIEW

Knowledge is an invaluable asset that fosters the development of people and organisations[11]. Knowledge Management (KM) is the strategic application of knowledge enhancement courses to increase an organisation's competitive advantage and value. By promoting sharing of information and accessibility among medical personnel, effective knowledge management in nursing may improve patient outcomes and the quality of care provided[12]. Knowledge production, acquisition, distribution, and retention are all part of the process of improving the knowledge base[13].

2.1 Knowledge Creation

Knowledge creation is an ongoing process that produces, validates, and shares new knowledge to improve patient outcomes, medical practices, disease understanding, treatment, and prevention. In order to create and update knowledge in addition to successfully respond to clinical situations, KCR in nursing requires creative efforts to produce novel concepts[14]. KCR in Health sciences demands collaboration between organisations, researchers, and practitioners; it involves people dealing with and solving new problems through training[15].

A number of strategies may be used to support the generation of new information, such as translational research, which links scientific investigation to clinical practice, and the conversion of laboratory results into clinically assessed therapies, diagnostic tools, or health interventions[16]. KCR patterns show interconnectivity and organising; nonetheless, their expression necessitates distinct contexts and situations[17–18]. Because of this, organisations that value Knowledge Creation (KCR) need to devote a large amount of funding to the advancement of KCR programs.

2.2 Knowledge Acquisition

Assimilation of knowledge from internal and external organisational resources involves discovering, accessing, capturing, and gathering sources, as well as examining anthropological, sociological, and technological aspects[19]. Acquiring medical expertise and knowledge, increasing medical education, and improving clinical outcomes all depend on the availability of knowledge resources in the healthcare industry[20]. By including students as collaborators and learners, the practical field of nursing education significantly enhances students' KAC[21].

According to Hassanian[4], *et al.* nursing professionals acquire knowledge through five generic categories such as "moving towards upstream purposes (causal condition)", "the relative dynamism (context)", "persuade to acquire knowledge and deficit of it (facilitator and inhibitor)", "relative acquisition of knowledge in nursing (processes)" and relative accumulation of knowledge (consequences).

2.3 Knowledge Capture

Knowledge capture involves the conversion of implicit knowledge into explicit knowledge, and vice versa. KCA in nursing encompasses collecting data from clients, family members, medical records, and references to understand their health condition, treatment reactions, and potential risks[22], documentation within formal clinical and academic publications[23] and capturing knowledge from the surroundings or individuals engaged within that surroundings[24].

2.4 Knowledge Sharing

The field of healthcare science is one in which medical knowledge is always expanding in an astronomical rate[25]. Sharing knowledge is therefore regarded as an essential strategy for collaborating to enhance clinical outcomes and patient well-being. The study conducted by Asurakkody and Kim[26] discovered a strong positive link between KSH behavior and creative work behavior in nursing students. Yoo[8], *et al.* found that there is a clear correlation between decision-making ability and the sharing of explicit knowledge. On the other hand, Shehab[18], *et al.'s* study observed that knowledge self-efficacy acts as a moderating factor in the link between information-sharing behaviors and the three individual characteristics of reputation, reciprocity, and trust. According to the Assem & Pabbi[27] study, informal meetings and conferences-rather than formal knowledge management systems-are the main source of Ghana's healthcare sharing of knowledge.

The healthcare industry places a high value on knowledge management, as it fosters professional collaboration and improves patient outcomes. A study by Karamitri[28], *et al,* identified the main elements of knowledge management practices in the healthcare industry as leadership, synthesis, collaboration, synthesis, and dissemination of knowledge. The study emphasises the difficulties in applying Knowledge Management (KM) in the healthcare industry and recommends that administrators establish a knowledge-centric workplace, act as models, supply the required resources, and give knowledge brokers with incentives[28]. Research on the effects of knowledge creation, acquisition, capturing, and sharing is lacking. This study is suggested in order to have a better understanding of KM practices in the Indian nursing profession. The following objectives guided our study:

- To examine the relationship between knowledge creation and knowledge sharing.
- To look at the relationship between knowledge acquisition and knowledge sharing.
- To study the relationship between knowledge capturing and knowledge sharing.

2.5 Construction of Hypotheses

Research studies on KM reveal that an organisation's capacity to produce, disseminate, and use knowledge efficiently has a major effect on its ability to survive and compete[29]. By producing and disseminating new information, knowledge sharing helps people learn more by exchanging knowledge. The relationship between knowledge creation and sharing has been the subject of conflicting research; although some studies have identified a substantial association[30-31], others have suggested a positive correlation[32]. The disparity may result from the selection of different study models, analytical groups, or sample units. The process of gaining and expanding new knowledge whenever one acquires it is known as knowledge acquisition[33]. Without strong factual support, knowledge sharing and acquisition are commonly seen as ambiguous and not easy[34]. An earlier study discovered that faculty members' attitudes and subjective standards are significantly affected by their knowledge acquisition and sharing[35]. Identifying and observing existing knowledge inside or outside of an organisation is an important procedure commonly referred to as "knowledge capture."

It is the methodical organisation and recording of undocumented inferred information for later retrieval or analysis. Research that has recently been published has shown that employee performance is significantly improved by knowledge sharing and capture[36]. Thus, knowledge sharing is an integral part of an innovation process and knowledge sharing directly enhances creativity and innovation[37]. This study attempts to explore the relationships between knowledge acquisition, sharing, and transfer and highlights their interconnectedness. Preceding studies have also reported how knowledge creation, acquisition, capturing, and sharing contribute to KM[38-39]. The review and findings of the previous studies helped us put forward the hypotheses below and a conceptual model (Fig. 1). The hypotheses are:

H_1: There is a positive relationship between knowledge creation and knowledge sharing.

H_2: There is a positive relationship between knowledge acquisition and knowledge sharing.

H_3: There is a positive relationship between knowledge capturing and knowledge sharing.

The relationship between knowledge sharing (the dependent variable) and the three independent variables including knowledge creation, acquisition, and capturing can be observed in the conceptual model that has been given below:

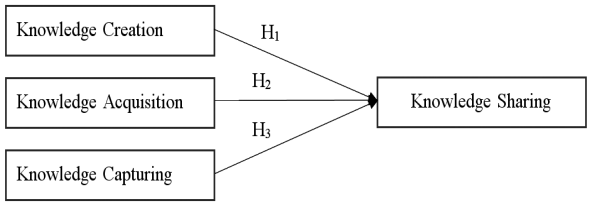

Figure 1. Conceptual model.

3. METHODOLOGY

3.1 Questionnaire Design

The questionnaire was created by the researchers using a variety of resources, including systematic literature reviews that were carried out specifically for the purpose of designing the questionnaire. The variables included in this investigation were chosen from the literature that has been published[13,40,41,42]. This survey is divided into two sections: the first part covers about the demographics of the respondents, and the second half contains the 27 items that make up the research variable. Each item is rated on a five-point Likert scale, where 1 represents strong disagreement and 5 represents strong agreement. As an example, the first question asked, "*I collect new information and make a connection between the new and the already available information*."

3.2 Study Sample and Data Collection

The study sample had been chosen in 2022–2023 from nursing schools affiliated with Pondicherry University. The Principals of Nursing Colleges affiliated with Pondicherry University helped in collecting data from students and research scholars for this study through an online questionnaire. The respondents for this study were drawn using a simple random sampling technique. In order to promote wider involvement, a structured questionnaire was circulated through social media. To get the most out of the participants, three reminders were given. A total of 1015 completed questionnaires were received, resulting to 49.10 % response rate (Table 1). At the end, 968 completed and valid questionnaires were used to evaluate the suggested hypotheses and 47 (4.63 %) responses were omitted due to incomplete data.

Table 1. Details of data collection and study

College	Sample	Response	Response rate (%)
Mother Theresa Post Graduate and Research Institute of Health Sciences	295	165	55.93
Indirani College of Nursing	380	163	42.89
College of Nursing, Pondicherry Institute of Medical Sciences	360	213	59.17
Raak Nursing and Paramedical College	180	85	47.22
College of Nursing, East Coast Institute of Medical Sciences	192	94	48.96
Sri Manakula Vinayagar Nursing College	330	145	43.94
Sabari College of Nursing	150	66	44
A.G. Padmavathi College of Nursing	180	84	46.67

4. FINDINGS

4.1 Demographic Profiles

After the data-cleaning process, a total of 968 responses were considered for analysis. Table 2 presents the demographic profile of the study population. Of the total, the majority (73.35 %) of the respondents were females, less than half (48.86 %) of them belonged to the 26-30 years age group, the majority (88.95 %) had a B.Sc. degree in nursing and about one-fifth (21.9 %) of the respondents are from College of Nursing, Pondicherry Institute of Medical Sciences.

4.2 Assessing Measurement Model

For each dimension in this study, the reliability of the items was assessed through Cronbach's alpha coefficient and Composite Reliability (CR). Table 2 provides the results of Cronbach's alpha and CR values. The composite reliability values exceeded 0.85, greater than the satisfactory value of 0.7, and the constructs' Cronbach's alpha values exceeded the recommended reliability value of 0.7[43]. Here comprehensive exercise was conducted to assess the validity.

First, to ensure content validity, we carefully selected scales from prevalent opinions based on the literature review.

Additionally, to improve participant understanding, we had subject matter specialists look into the questionnaire multiple times to get feedback on simplifying the language. In addition, the Comparative Fit Index (CFI) of 0.980 indicates a significant degree of fit to the data. Convergent Validity (CV) was assessed by the confirmatory factor. Similarly, the Tucker–Lewis Index (TLI) is 0.976, confirming a good fit. Additionally, the Incremental Fit Index (IFI) also stands at 0.980, supporting the model's adequacy. Finally, the root mean square error of approximation (RMSEA) is 0.052, suggesting a close fit to the data (Fig. 3). All these indices were more significant than the minimum recommended values, and all factor loadings were greater than 0.70, and significant at the $p<0.001$ level[43]. Additionally, Average Variance Extracted (AVE) was examined to determine the amount of variance of the measurement items that the constructs can account for concerning measurement error. According to Table 1, all AVE values for each construct are greater than the suggested value of 0.5[43], which supports the convergent validity measures.

Table 2. Demographic profiles

Item	Category	Frequency	Percentage
Gender	Male	258	26.65
	Female	710	73.35
Age	21-25	283	29.24
	26-30	473	48.86
	31-35	128	13.22
	36-40	46	4.75
	41 & above	38	3.93
Education	UG	861	88.95
	PG	91	9.40
	Research Scholar	16	1.65
Colleges	Mother Theresa Post Graduate and Research Institute of Health Sciences	146	15.08
	Indirani College of Nursing	156	16.12
	College of Nursing, Pondicherry Institute of Medical Sciences	212	21.9
	Raak Nursing and Paramedical College	79	8.16
	College of Nursing, East Coast Institute of Medical Sciences	86	8.89
	Sri Manakula Vinayagar Nursing College	143	14.77
	Sabari College of Nursing	64	6.61
	A.G. Padmavathi College of Nursing	82	8.47

Table 3. Item loading, reliability, CR and AVE

Constructs	Item	Loading	Cronbach's α	CR	AVE
Knowledge Creation	1	0.90	0.976	0.974	0.809
	2	0.91			
	3	0.92			
	4	0.90			
	5	0.91			
	6	0.90			
	7	0.89			
	8	0.89			
	9	0.86			
Knowledge Acquisition	1	0.92	0.973	0.973	0.818
	2	0.85			
	3	0.93			
	4	0.91			
	5	0.92			
	6	0.93			
	7	0.87			
	8	0.89			
Knowledge Capturing	1	0.90	0.947	0.947	0.782
	2	0.81			
	3	0.92			
	4	0.92			
	5	0.87			
Knowledge Sharing	1	0.91	0.875	0.858	0.671
	2	0.67			
	3	0.86			

Notes: CR:Composite Reliability, AVE: Average Variance Extracted

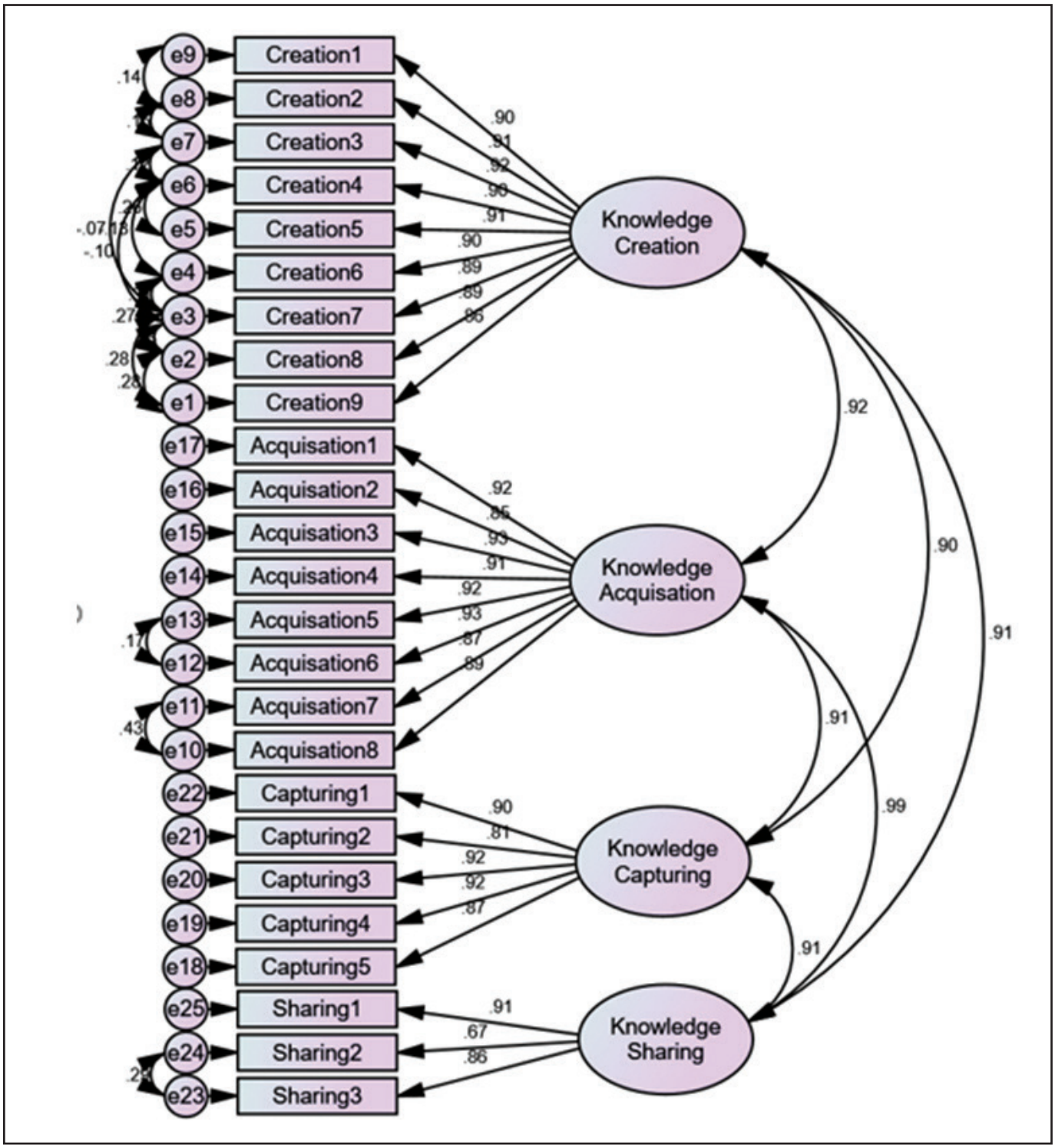

Figure 2. Factor model of knowledge management practice.

To calculate discriminant validity, we computed the square root of AVE for the respective construct and equaled it to correlations between the construct pairs[43]. The square root of the respective construct's AVE value was more significant than its correlation with any other construct, as shown in Table 4 thus, this study's discriminant validity was proven. Based on the above findings, this study's reliability and validity estimations are quite satisfactory.

Table 4. Discriminant validity test

Variables	Mean	SD	KSH	KCR	KAC	KCA
KSH	3.392	1.190	0.819			
KCR	3.545	1.206	0.906	0.899		
KAC	3.606	1.243	0.987	0.923	0.904	
KCA	3.477	1.174	0.913	0.900	0.914	0.884

Notes: SD: Standard Division, KSH: Knowledge sharing, KCR: Knowledge creation, KAC: Knowledge acquisition, KCA: Knowledge capturing

4.3 Structural Model Valuation

The path coefficients and R^2 values were estimated as part of the structural model's valuation (Fig. 3). We discovered that knowledge creation ($\beta = 0.091$, $p < .05$), knowledge capturing ($\beta = 0.182$, $p < .05$) and knowledge acquisition ($\beta = 0.609$, $p < .05$) have a positive impact on knowledge sharing (Table 5). Linear regression is used to find the equation that generates the least amount of difference between the observed values and their fitted values. The R2 value for knowledge-sharing was 0.67, indicating that it fits within an acceptable range and is therefore acceptable[43].

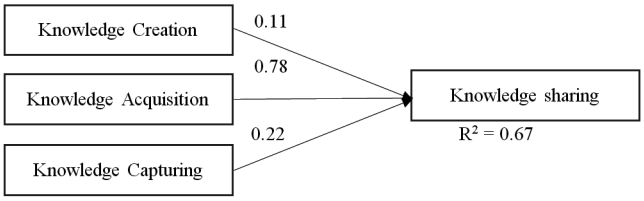

Figure 3. Final model with beta coefficients.

Table 5. Result summary

Hypothesis	Interaction	Coefficient	p-value	Conclusion
H_1	KCR → KSH	0.091	0.015*	Supported
H_2	KAC → KSH	0.609	0.014*	Supported
H_3	KCA → KSH	0.182	0.015*	Supported

Notes: KCR: Knowledge Creation, KAC: Knowledge Acquisition, KCA: Knowledge Capturing, KSH: Knowledge Sharing.

5. DISCUSSION

Profili[25], *et al*. found that nursing is one in which new knowledge is constantly being created continuously. Akhavan[30] et al., express that creating new knowledge presumes that people will identify important data, information and transform it into knowledge that will benefit the organisation. The primary focus of this study was to examine the relationship between creation of knowledge, acquisition, capturing and knowledge sharing among nursing professionals. Storey and Kelly[44] highlighted a positive atmosphere, organisational inventiveness, and a common goal are necessary for a knowledge creation learning culture. Knowledge sharing is characterised by common understanding, active communication, empowerment, and teamwork. As more knowledge is generated, it will eventually be shared more. Hence, institutions need to offer opportunities and resources for the creation of new knowledge that will improve the organisation's overall reputation. There is little evidence linking the creation and distribution of information. Akhavan[30], *et al.* found no evidence of any meaningful association[32], despite several research showing a positive correlation. The discrepancy may arise from selecting different sample units, analytical levels, or research models. The findings of this study indicate a positive relationship between knowledge creation and knowledge sharing; therefore, these results support the opinions of Akhavan[30], *et al.* studies.

When there is not enough of substantial scientific evidence, knowledge acquisition and sharing are usually viewed as unclear and problematic[34]. According to previous research by Abdekhoda[35], *et al.* faculty members' attitudes and subjective standards are significantly influenced by the knowledge they learn and communicate. Agrifoglio[45], *et al.* explain that knowledge is acquired through various educational models and techniques, such as lectures, discussions, work-related examples, play-acting, behavioural demonstrating, on-the-job training, and learning by networking with others, which is additionally made more accessible by training programmes. Adam[46], *et al*. study shows that knowledge acquisition has a direct positive correlation with knowledge sharing and affects the quality of competitive advantage because it has a direct effect on knowledge sharing However, the result contradicts the results of previous studies. This study's findings indicate a positive relationship between knowledge acquisition with knowledge sharing.

Zamir[47] analysis revealed a favorable correlation between knowledge capture and knowledge sharing; however, these findings differ from those of previous study results. Pacharapha and Ractham[16] explain that it may be due to the receiver's prejudgments that influence individuals' knowledge acquisition. The influence depends on how knowledgeable a person is about the subject they have learned, whether he/she is an expert or a novice. According to a study by Suardy and Budiono[36], employee performance is significantly improved by knowledge capture and dissemination. This study result reveals a positive correlation between knowledge capturing and knowledge sharing. The study's findings offer new insights into the contributions nursing professionals made to the field of KM and its practices. These results provide valuable insights for nursing professionals in creating, acquiring, capturing, and sharing their knowledge. Overall, these results confirmed that knowledge creation, acquisition, and capture positive impact on knowledge sharing.

6. CONCLUSIONS

Knowledge is a vital strength for an organisation to gain a competitive advantage. Nursing professionals require different platforms to create, acquire, capture, and share knowledge. It is widely acknowledged that knowledge plays a vital role in society and that knowledgeable employees are the most valuable assets in any organisation. Thus, institutions must foster innovative ideas and enable individuals to create, acquire, capture, and share knowledge. This research contributes to a better comprehension of KM practices in healthcare organisations, by establishing the association between creation, acquisition, capture, and knowledge sharing among nursing professionals. As a result, this research expands the understanding of how knowledge is managed among nursing professionals. These results apply to all nursing organisations where healthcare delivery is a team effort that unites the widely dispersed and fragmented body of medical knowledge. While the primary emphasis of this study is nursing professionals, KM is essential in all organisations that

demand extensive knowledge. The results of this study would direct institutions to capitalise on the management process, and more precisely, on knowledge sharing among nursing professionals.

This study presents several limitations that pave the way for future research. Firstly, it focuses solely on examining the connection between KM practice, including knowledge creation, acquisition, capturing, and sharing. Additional investigations could explore the impact of other variables as moderators in the relationships between KM practices and endogenous constructs. Future research may build on the results of this study by incorporating specific KM enablers into the conceptual model and investigating the relationships between these variables. In addition, to further highlight this crucial facet of KM, studies into the nature of nursing professionals' knowledge-hiding behaviours inside healthcare organisations are to be investigated. In summary, this study lays the foundation for further exploration in the field, suggesting potential avenues for research that encompass broader perspectives on KM practices and incorporate additional factors influencing the outcomes in various organisations.

People need to gather important data and turn it into knowledge with consequences for research, practice, and policy. In our Teaching we must include techniques for role-playing, lectures, discussions, and group projects promote knowledge acquisition and information exchange. Consequently, businesses need a clear objective, an innovative learning environment, and an appropriate atmosphere for learning. Hence, organisations should support the creation and sharing of new knowledge since these endeavors improve nurses' expertise and ability to share information. Moreover, there is a need for further research on Knowledge Management (KM) strategies that adopt a more comprehensive approach and consider other factors that may affect the outcomes in different organisational contexts. Organisations should also focus more on how nurses share and apply their skills and knowledge.

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