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Nutrition & Hydration

Current Awareness Bulletin

November 2025

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  Next sessions: 7th January 2026 @ 2pm and 19th February 2026 @ 3pm

Book a session today at https://forms.office.com/e/HyiSXfDaYV (these sessions will be held on a monthly basis)

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1. **Perception of primary-secondary care collaboration among general practitioners and specialists and the perceived potential for innovation: an exploratory qualitative study**

Authors: Crasborn, Malou;van Aken, Maarten,O.;van der Hoeven, Bas,L.;Numans, Mattijs E.;van Smoorenburg, Sam;Pepping, Rianne M. C. and Vos, Rimke C.

Publication Date: 2025

Journal: BMJ Open

Abstract: Competing Interests: Competing interests: None declared.; Objectives: Our objective was to examine the barriers and facilitators encountered by primary and secondary healthcare professionals when collaborating at the care continuum between primary and secondary care. We aimed to identify specific challenges, observed benefits and proposed changes. By analysing these experiences and identifying opportunities for redesign, we aimed to define specific domains that could improve collaboration, thereby supporting sustainable access to and quality of care in the face of rising demand and constrained resources.; Design: A qualitative exploratory study using semi-structured interview data guided by two domains of the Consolidated Framework for Implementation Research (CFIR), including Inner Setting-Tension for Change and Individual Characteristics, as well as selected implementation outcomes defined by Proctor et al , all viewed through a service (re)design lens.; Setting: Consultation and communication between primary and secondary healthcare professionals in a Dutch urbanised area.; Participants: 37 users of collaboration services (eg, telephone, correspondence) were interviewed between August 2021 and October 2022, including 14

general practitioners (GPs) (10 females, 4 males) and 23 specialists (10 females, 13 males).; Results: Four key domains with subthemes, subdivided per operation and CFIR domain, were identified as central to optimising the collaboration of professionals within the primary-secondary care continuum: (1) software and record integration; (2) seamless personal interaction; (3) eliminating a sense of 'us vs them' and (4) gaps in continuity of care.; Conclusions: This study reveals that healthcare professionals in both primary and secondary care face similar collaboration challenges due to system-level issues and inadequate collaboration tools, leading to increased workload, miscommunication and reduced quality of care. Improving collaboration between GPs and specialists requires not only adjustments to individual services, but a comprehensive overhaul of the referral and back-referral process. A more integrated approach, addressing key domains, is crucial for enhancing care quality, streamlining workflows and improving health outcomes. (© Author(s) (or their employer(s)) 2025. Re-use permitted under CC BY-NC. No commercial re-use. See rights and permissions. Published by BMJ Group.)

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2. **Innovative approaches to collecting, aggregating, and analyzing adverse drug events in smart hospitals**

Authors: De Pretis, Francesco;van Gils, Mark;Varheenmaa, Markus;Tiihonen, Miia and Forsberg, Markus M.

Publication Date: 2025

Journal: International Journal of Risk & Safety in Medicine

Abstract: Background: The increasing integration of electronic health records (EHRs) and their secondary use provide new pathways to advance drug safety. Smart hospitals use advanced data collection to enhance pharmacovigilance and better detect adverse drug events (ADEs). Finland's secondary-use legislation embodies this data-sharing shift. Objective: This work synthesizes current evidence and proposes strategies to strengthen ADE detection and analysis in smart hospitals by integrating multimodal data sources, including EHRs, sensor data, and the Internet of Medical Things (IoMT), to raise overall drug safety standards. Methods: We review the Global Trigger Tool (GTT), sensor technologies, and IoMT for ADE detection and outline how these techniques can be combined, offering a more comprehensive approach to monitoring. Results: Integrating GTT, sensors, and IoMT into a unified system could improve ADE detection and prevention. Combining pharmacovigilance tools with advanced technology can increase the volume and quality of ADE data and supports a preventive focus on patient safety. Conclusions: The study underscores the importance of the smart-hospital concept and emerging data-collection methods in pharmacovigilance. By adopting a holistic approach to ADE detection and integrating diverse data sources, more robust drug-safety surveillance and patient care can be achieved when coupled with human oversight and regulatory compliance.

3. **Patient safety ratings of hospitals by registered nurses, managers, and executives: A retrospective analysis of patient safety culture data.**

Authors: Jan Emory D. and Kippenbrock, T. A.

Publication Date: 2025

Journal: Nursing Outlook

Abstract: Background: Patient safety is a foundational component of healthcare quality, shaped by organizational culture and frontline engagement. A strong patient safety culture (PSC) promotes transparency, teamwork, and accountability to reduce harm and improve outcomes.
Purpose(s): This study examined differences in PSC perceptions among registered nurses (RNs), managers, and executives in U.S. hospitals to identify gaps that may impact safety initiatives.
Method(s): A retrospective analysis was conducted using data from the AHRQ Patient Safety Culture Survey 2.0, collected between 2020 and 2022. The final analysis included 77,981 responses.
Discussion(s): Statistically significant differences ($p < .001$) were found across roles. RNs reported less favorable perceptions of PSC, particularly regarding staffing adequacy, psychological safety, and leadership responsiveness. Effect sizes were largest among RNs and executives.
Conclusion(s): These findings highlight a disconnect between frontline experiences and leadership perceptions. Addressing these gaps through inclusive safety planning and cross-level collaboration is essential to strengthening PSC systemwide.

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4. **Factors Associated With Patient Safety Activities of Clinical Nurses: A Cross-Sectional Secondary Data Analysis**

Authors: Lee, JuHee;Nam, Keum-Hee;Suh, Yujin;Lee, Yoonju and Lee, Deokhyun

Publication Date: 2025

Journal: International Nursing Review

Abstract: Aims: To examine the associations between patient safety silence, culture, competency, and activities among clinical nurses.; Background: Patient safety ensures harm prevention and quality of care. Factors such as silence, culture, and competency are widely recognized as significantly associated with patient safety activities, but limited research has examined their interrelationships.; Design: Cross-sectional secondary data analysis.; Methods: This study used data from a study that investigated the patient safety educational needs of 291 nurses from general hospitals located in the Busan, Ulsan, and Gyeongsangnamdo regions of South Korea. To assess patient safety activities, silence, culture, and competency, the study employed the Patient Safety Activities Questionnaire, Patient Safety Silence Scale, Hospital Survey on Patient Safety Culture, and Patient Safety Competency Self-Evaluation Tool, respectively. The analysis involved descriptive statistics, correlation analysis, and multiple

regression using SPSS 27.0.; Results: The factors of silence and receiving patient safety education only once were negatively associated with patient safety activities. Positive associations were found for teamwork within the culture subdomain, skills within the competency subdomain, and hospital size.; Conclusions: These findings provide a basis for educational programs to improve nursing skills and highlight the need to build an open and collaborative organizational culture.; Implications for Nursing: Clinical nurses should develop patient safety skills, report patient safety incidents, and collaborate with team members to foster an open and cooperative organizational culture.; Implications for Nursing Policy: To minimize silence, while strengthening teamwork, organizations actively foster a culture of openness and collaboration. Education should be managed to meet minimum standards, and hospital-specific policies should be tailored according to each institution's size and characteristics. ()

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5. **'Leanomics' in healthcare: a three-year quality improvement study on the financial impact of a modified Kanban system in hospital storerooms**

Authors: Logrono, Kenneth Jun;Zu'bi, Belal,Salem Mufadi and Siddiqui, Raana

Publication Date: 2025

Journal: BMJ Open Quality

Abstract: Competing Interests: Competing interests: None declared.; Background: Manual inventory management in hospital storerooms often relies on visual estimation, leading to inaccuracies and inefficiencies such as overstocking and out-stocking. Our audit revealed that a medical inpatient unit incurs weekly consumable costs of QAR 31 000 (US$8500), underscoring the financial impact of these inefficiences. While traditional Kanban systems have proven financially effective in specialty units, their use in inpatient settings is limited, and data on their financial impact in Middle Eastern and North African (MENA) healthcare systems are scarce. This study aims to redesign the traditional Kanban system and evaluate its long-term financial and operational impact.; Methods: We applied the Model for Improvement framework while using Plan-Do-Study-Act cycles to test and refine interventions. The traditional Kanban system was redesigned by introducing replenishment triggers, adopting bin systems, implementing Kanban boards, and standardizing Kanban quantities based on the frequency of consumable use. Impact was assessed using statistical process control charts generated with QI Macros software. Outcome measures included total weekly consumable costs; process measures assessed staff compliance with the Kanban system; and balance measures tracked out-stocking rates and staff satisfaction.; Results: Over three years, the modified Kanban system reduced weekly costs by 40-50%, from QAR 31 000 (US$8500) to QAR 19 000 (US$5100) during testing and stabilised at QAR 16 000 (US$4300) post-implementation. Staff satisfaction increased from 79% to 90%, driven by improved workflow and inventory tracking. Out-stocking rates declined from 0.04 to 0.02 per 1000 inpatient days during testing, ultimately reaching near zero after implementation. Compliance improved from 76% to 95%, directly contributing to both cost savings and operational efficiency.; Conclusion: The modified Kanban system effectively reduces costs, enhances staff satisfaction and improves operational efficiency by minimising stockouts. This study underscores the value of quality improvement and lean methodologies, such as Kanban, in optimising healthcare supply

chains and reducing waste. (© Author(s) (or their employer(s)) 2025. Re-use permitted under CC BY. Published by BMJ Group.)

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6. **Therapeutic violence mitigation: Innovation in hospital violence prevention.**

Authors: Sahota P.;Glickman C.;Doremus C.;Gandhi S.;Aplin K.;Fox N. and Kupersmith, E.

Publication Date: 2025

Journal: Journal of Hospital Medicine

Abstract: Violence in hospitals poses a vexing and increasingly urgent problem. At Cooper University Hospital, we recently developed the therapeutic violence mitigation (TVM) initiative. Innovations in TVM include the use of technology, automated text notifications, and tailored care plans for patients at risk for violence. Pilot results show substantial decreases in violent events for patients receiving TVM interventions.

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7. **Bar code scanning of ready-to-feed enteral nutrition formulas improves patient safety and reduces risk of misadministration in pediatric patients ages 1-18: A quality improvement project in a single children's hospital.**

Authors: Steele C. and Albert, D.

Publication Date: 2025

Journal: Nutrition in Clinical Practice

Abstract: The safe use of enteral nutrition (EN) for patients of all ages in the healthcare setting is often taken for granted. However, an increasing body of literature highlights potential failure points even when using ready-to-feed (RTF) enteral formulas. Potential risks include administering a wrong, expired, or recalled formula which could result in patient harm including under or over nutrition, allergic reactions, gastrointestinal intolerance, metabolic or electrolyte disturbances, and/or consequences related to contamination. This quality improvement project reviewed the frequency of having the wrong RTF EN formula scanned for the wrong individual (defined as a near miss) in pediatric patients 1-18 years of age. During the time of this evaluation, a total of 48,044 RTF EN formula feeding attempts were recorded. Of those attempts, 46,648 were successful, with the RTF EN formula matching the patient's EN order when the patient's armband and EN bar code were scanned. The remaining 1396 attempts represented near misses in which the product being scanned was not the correct product for the patient (a rate of 2.9%). Although this rate may seem low, the number of near misses during this time frame means that, on average, 48 times per month or 1.6 times per day, the bar code scanning system is preventing a pediatric patient from receiving the wrong EN formula. The data from this performance improvement initiative support the organization's decision to scan EN formulas at the time of administration and underscores the importance of following protocols to ensure that scanning occurs every time when administering formulas to reduce risk of error.

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8. **Patient safety: transforming a hospital-wide daily staff huddle**

Authors: Watson, David

Publication Date: 2025

Journal: Nursing Times

Abstract: After an inspection raised substantial patient safety and staffing concerns at a hospital, staff collaborated to revise the format of their daily site safety huddles. It was previously felt that these focused solely on patient flow rather than safety; they were changed with the aim of helping staff to identify safety concerns, learn from adverse events and, ultimately, improve the wellbeing of both patients and staff. Following the revision, a further inspection of the hospital reported that the huddles now foster a culture of safety.

Sources Used:

A number of different databases and websites are used in the creation of this bulletin.

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