Safety-critical area	Implementation issues identified in incident review	Paediatric Review	Neonates Review	Adult Review
Local policies and protocols These need to reflect all the safety-critical requirements summarised.	Some incident investigations suggested that local policies and protocols omitted key aspects of the earlier alerts Some incident investigations suggested policies and protocols were unclear, or too lengthy for frontline staff to realistically be able to read or remember their content.	Since SI policy has been updated	2 polices –NNU-Gastric Feeding tubes on the Neonatal Unit and Nasogastric Feeding at Home (Outreach). Both need reviewing and table of safety-critical requirements added. To be ratified at next WaCH Governance meeting ? policy to part of a Trust enteral feeding policy	New policy clearly identifying all aspects of previous alerts. Clear concise policy that reflects all the safety-critical requirements. New documentation on insertion and management of NGT (end of bed) NPSA compliant with identified NEX, point of nostril and continuing care. Trust wide roll out of new Competencies and training for nursing staff with a compliance of two yearly updates.
National safety guidance referring to any incident investigations.	Investigation summaries almost never refer to NPSA alerts or actions required within them, and appear to rely on local policy or the investigators' understanding of good practice.	The Trust runs RCA investigation training which includes a practical element. Key documentation that requires review as part of the data gathering; mapping and analysis is covered the trainer talks about the inclusion of alerts as appropriate/relevant to the incident; NICE guidance; other National policies/frameworks; local polices etc. The SI investigation report template has a section entitled 'Information and evidence gathered' it has been amended to include specifically reference to alerts as appropriate and relevant to the incident being investigated.	As stated	As stated
Safe equipment Nasogastric tubes are radio-opaque throughout their	Safety equipment appears to have been introduced at the time of the NPSA 2011 alert (if it was not already in use).	All naso gastric tubes are radio-opaque and have visible length markings pH paper is CE marked	All Gastric tubes are radio-opaque throughout their length and have visible external length markings.	Naso-gastric tubes used within East Surrey Hospital are all NPSA compliant. Procurement only order the 'Nutricia Flocare Pur tube', this is the only NGT inserted within the hospital.

length and have externally visible length markings. pH paper is CE marked for use on human aspirate.	Isolated cases when a later decision to change suppliers for cost effectiveness meant that non-compliant nasogastric tubes were re-introduced.		Using Merck pH indicator papers. 2 types of Merck strips in cupboard – one without CE mark- to ensure all future orders are for the CE marked tubes.	Transferred patients into the hospital will have to be identified and ensured that the tube insitu is compliant. Merck (Corflo) PH Indicator strips CE marker: only indicator strip used in East Surrey Hospital.
Competency-based training Training needs to reflect all the safety-critical requirements summarised in this resource set.	Not all trusts appear to have created ongoing training programmes, or levels of training completion had not been routinely monitored and had lapsed.	All staff read the policy, complete a core assessment and practical assessment. Compliance is reviewed by ward managers	Competency undertaken on all new staff – this is retained by them in their portfolio Follow up assessment not practical. To undertake a competency assessment on all staff at next teams with presentation and discussion (Band 4 staff - 12/01/17), Band 5 staff – 25/01/2017) and band 6 staff (16/02/2017). Thereafter update to be undertaken annually on team days. No competency for medical staff checking tubes on x-ray	New Trust wide competencies training roll out collaborating both practical and theoretical teaching with ongoing assessment at ward level. Records of all trained will be identified on Health Roster. Two yearly competencies updates Doctors: eLearning training regarding X-ray. Any doctor inserting Nasogastric tube would require competency training. **This is where an eLearning trust wide package would benefit.**
Clinical documentation formats and checklists These need to reflect all the safety-critical requirements summarised in this resource.	From the investigations it was not clear if all trusts provided structured documentation or checklists to record nasogastric tube insertion and subsequent checking requirements.	Paediatric of nasogastric/orogastric tube insertion and correct placement checklist commenced on insertion of ng tube	Checklists laminated in every care plan. NGT/OGT placement, size and measured entered daily on the Safety Check list. Aspirate/pH entered prior to every feed in allotted column on feed chart	New end of bed documentation, with clear pathways to alert safe use. Rationale for feeding identified with signatures **(further discussion regarding grading)** Identified NEX measurement on initial placement, point of nostril, +/- X-ray required. Clear continuation structured format for staff
Ongoing audit of compliance	Some investigations suggested that some policies written after the	Under Divisional Audit programme. Audit planned for February 2017	Review of policies Evidence of compliance needed in staff files	Ongoing yearly audits

	2011 alert had had little impact on clinical areas. Initially good compliance had lapsed over time, but these lapses were only noticed after a Never Event occurred.		Ongoing assessments at annual team days	
Implementation of Patient Safety Alerts	Following the review of nasogastric tube investigations, omissions in the implementation of safety critical guidance from previous nasogastric tube alerts has become apparent. If there were gaps in organisational systems for ensuring alerts were acted on, these could potentially apply to other alerts.	The Trust has a CAS liaison officer in post; there is a Management of Safety Alerts Policy; the use of Datix-web for alerts has been piloted and is due for launch on 16th January 2017; Divisional chiefs and their representatives and procurement are involved in the receipt; assessment; cascade as relevant and completion of alerts; NHS Patient Safety Alerts are owned by Executive members who have to sign these off; all alerts are monitored for assurance of completion and assurance that recommendations/actions have been completed through the Patient Safety Committee and the Divisional Governance Committee's; closure of alerts is included on the Trust performance scorecard	As stated	As stated