

Name Kay Armstrong

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Telephone Number

Occupation Cardiac Sister

Date of Birth Over 21

Background

1. I qualified in March 1976 in Gloucester. Between 1977 and 1979 I worked at Kings College Hospital, London where I occasionally worked in cardiac theatres although I mainly worked in whatever theatre suite I was needed. I did my ENB 176 theatre course whilst at Kings. From 1979-1980 I worked at Frenchay Hospital as a Sister in the Plastic Surgery Theatre. In 1980 I took up an agency job in Holland working at Juliana Ziekenhuis, Appledorn in theatres for one year. I returned to England in 1981 where I worked in Gloucester until 1984 as a Theatre Staff Nurse.
2. I started working at the BRI in October 1984 as a Staff Nurse in cardiac theatres, Level 4. In 1986 I was promoted to Sister. In 1988 I moved to night duty in the Greg Smith Theatres covering maternity leave and then returned to cardiac theatres, Level 4. In 1993 I completed my anaesthetic course 182 and ENB (998). From 1994 I shared a sister post, for two days as an anaesthetic sister and two days as a surgeon's assistant. I went on maternity leave in 1995 and on my return transferred to my present post as cardiac sister at the Bristol Royal Hospital for Sick Children (BRHSC).

Issue B1 : The structure of Paediatric Cardiac Surgical Services at the respective sites at the BRI and BRHSC

Issue B1a : the services offered.

3. The Level 4 Theatres were shared between the cardiac surgeons and day surgery. In 1984 the situation was that Theatre 1 was for all day surgery, Theatre 2 was used for cardiac surgery all day on Mondays and a morning session on Tuesdays. For the remainder of the week it was used for day surgery. Theatre 3 was only used for cardiac surgery. Most of the cardiac equipment was stored in Theatre 3 and all paediatric cardiac surgery took place in theatre 3.
4. When I first started in 1984 as a staff nurse in cardiac theatres there were approximately 11 nursing staff including myself. Porterage was covered from a pool area. We were supplied with a porter each day. We were not responsible for porter coverage.
5. In 1986 I was promoted to sister. Between 1986 and 1988 the situation was that one theatre, Theatre 3, was in constant use for day surgery. Theatre 2 was in use twice a week for cardiac surgery and one theatre was used just for cardiac surgery (day and night). I do not think that there was a great deal more staff during this period. Initially we were only allowed one person to cover nights but we were allowed to increase this to two.

6. In July 1988 the cardiac surgery expansion took place and staff numbers increased. However, it was very hard to find out from management what our staffing allocation should have been. Day surgery moved to theatre 3 and cardiac surgery took over theatres 1 and 2. These theatres shared a scrub up area which made it easier to run the cardiac sessions simultaneously. All paediatric cases took place in theatre 1 which was the larger of the two theatres.

7. The perfusion service was run entirely separately from the theatre department and was managed by Don Caddy, the Chief Perfusionist. The senior nursing staff in the theatre had no input at all as to the type of equipment used or any perfusion ordering. Mr Caddy also took all responsibility for the ordering and storage of the prosthetic valves together with the maintenance of the blood gas machine.

Issue B1c : organisational set-up: lines of authority, chains of command, communication and accountability, both professionally and managerially.

8. As sisters we were accountable to the Theatre Nursing Officer, Miss McKenzie, who in turn was accountable to the Director of Nursing Services. The sisters were responsible for the day to day running of the theatres but did not hold the budget or have any control over the staff numbers allocated to each theatre. This was very frustrating as we were frequently understaffed without the power to do anything about it.

9. In 1984 the Director of Nursing Services was Miss Gerrish and the Theatre Nursing Officer was, as I have already said, Miss MacKenzie. In the following years

leading up to 1995 the management structure changed frequently and often with little warning. The cardiac theatre had 6 different managers over this period (Alison Whiting, Gill Kelly, Lesley Salmon, Julia Thomas, Fiona Thomas and Rachel Ferris). After Miss Gerrish left the nursing staff felt that there was no-one at management level specifically designated to look out for nurses' interests. Miss Gerrish's role was taken up in a general management post. This was the end of the Director of Nursing Services post.

10. It was around this time that clinical grading was implemented and all the Theatre Staff received a low grade. Comment was made by one of the managers, that a monkey could be trained to work in theatres! Although an apology was later made to the theatre staff the damage had been done and some staff left. After several months of appeals most theatre staff were upgraded but the whole issue had made recruitment of theatre staff extremely difficult and we did lose staff.
11. When Cardiac Services became a directorate the manager delegated the job of managing cardiac theatres to one of the ICU sisters. This was instigated by Lesley Salmon in 1991. We were still suffering recruitment problems. It was very difficult running theatres at this time and being managed by someone who did not understand how theatres worked. We were being asked to work shift patterns which were unworkable. Again, we were losing staff who would not put up with the working conditions. This situation continued up to 1995 when I moved to work at the BRHSC.

Issue B1d : the extent to which medical and nursing staff were involved in management and managerial issues.

12. There are 4 distinct areas of management; medical, nursing, perfusion and portering.
13. The nursing responsibilities of running cardiac theatres, which is essentially my responsibility as sister, includes:
- Staffing, both recruitment and training
 - Daily organisation of the running of the theatre lists
 - Maintenance and ordering of equipment and stores
 - Health and safety, for example providing a safe environment for the patients and everyone working in theatres.
14. Perfusion is managed independently as is portering. I was not responsible for the budget. This would have been the nursing manager's responsibility.

Issue B1e : facilities available at each site, including their use by other services, e.g. adult cardiac surgery.

15. We were catering for both adult and paediatric cardiac surgery. From a theatre perspective it did not make any difference. We had all the necessary equipment for paediatric cardiac surgery, therefore we were not providing an inferior service to that provided now at BRHSC. Most of the equipment from the BRI has moved up to the BRHSC with us.

16. The theatre system was described at B1a. After surgery patients were transferred to the Cardiac Intensive Care Unit which was situated two floors up on Level 6. They were transferred using a portable ventilator and monitoring system. All patients were accompanied by an anaesthetist, one of the cardiac SHO's, a member of nursing staff and a porter. I attach a sketch plan of the theatres to this statement (Annex 1).

Issue B1f : staffing: numbers, natures of posts held, criteria for appointment and employing body, training and experience, job plans or descriptions and their review, and patterns of deployment (such as the use of shared appointments and the rotation of skilled staff);

17. Staffing recruitment has always been a problem in cardiac theatres due mainly to the long hours and on-call commitment. This was a national problem especially in cardiac theatres where qualified on-call staff are needed but the pay is very poor.
18. The work force is made up of RGN, SEN, and ODP (Operation Department Practitioner) trained staff. For most of the time the staff were multi-skilled and worked on the scrub side and also in the anaesthetic room. However, it was felt that there should be separate scrub and anaesthetic nurses so that the anaesthetists were working with the same staff to provide continuity. This was why I enrolled on the anaesthetic course in 1993. In 1994 it was decided to have separate anaesthetic and scrub staff. Although all advertisements for cardiac theatre staff stated that previous cardiac experience was necessary, in reality most staff employed had no

previous cardiac experience and therefore had to be trained before they could take on any on-call commitment.

19. The advent of Project 2000 students has not improved the situation because there is no requirement in their training that they must work in theatres. Prior to Project 2000 training, nurses would have done an average six weeks training in theatres. I myself did three months training in theatres. I think theatre work should be a mandatory part of nursing training because, at the moment, people are not given an opportunity to see whether they like working in theatres. If it is not a course requirement the temptation may be to avoid it.

Issue B1g : regulatory and disciplinary structures

20. All qualified nursing staff are answerable to the UKCC codes of conduct. Also theatre work adheres to the guidelines set down by the National Association of Theatre Nurses (NATN). ODA/ODP staff belong to the Professional Technical Body (PTB) part of the Whitley Council and have a voluntary code of conduct to BODA. Membership of BODA is not a legal requirement. There is no official register for either ODAs' or ODPs'.

Issue B1h : counselling and support for staff

21. Support was provided for theatre staff by the sister in charge of the department during most of the relevant period. For a while there was a nurse counsellor post

paid for by the Heart Circle, Helen Stratton. She was responsible for supporting the parents whilst their children were in hospital. She also made herself available to any of the theatre staff who needed support and/or counselling at various times. All staff found Helen Stratton's input very beneficial and she was greatly missed when she left in March 1994. No replacement was appointed due to lack of funds. Her duties were taken over by Freda Gardner, a psychologist. Freda Gardner was not really thought of as someone accessible by theatre staff. I was not aware of anyone else appointed by the Trust to provide staff counselling/support. I would have had to physically look for any such service as I was not aware that any was offered.

22. During the period in question theatre staff were dealing with a lot of long hard cases, sometimes with children dying, if not whilst in the Operating Theatre, when they returned to the ward. Theatres became a depressing place to work. I did feel the need for someone to give me support. I would not say that working in theatres meant specialist theatre nurse counselling support was needed. It is not the same at the BRHSC where working with Mr Ash Pawade is far less stressful.

Issue B3 : The effect of the creation of the UBHT in April 1991 on the financing, organisation, management and delivery of the paediatric cardiac services at the BRI

23. The creation of the UBHT in 1991 and the directorate structure did not make much difference to us on the ground. The requirement was the same, to provide the service as safely as possible within the budget. One effect of becoming a Trust meant that we were divided into separate directorates. Cardiac theatres initially

came under the Surgical Directorate and then, later formed part of the Directorate of Cardiac Services. The structure of management for us then became:-

Clinical Director, Cardiac Services Manager and Cardiac Theatre Manager. The cardiac sisters were given no control over our theatre budget or staffing numbers.

Issue B5 : The nature, scope and use of mechanisms and procedures (whether formal or informal) for establishing, monitoring and maintaining (a) safe treatment and care; (b) high quality treatment and care; (c) professional competence and (d) managing costs; and/or for monitoring clinical outcomes and adverse events.

24. Monthly meeting of the Cardiac Services Directorate were held to discuss finance, contract and patient care issues. I usually attended these meeting on Tuesday evenings after work so that I would know what was going on. I was initially invited along by Mr John Hutter, Consultant Adult Cardiac Surgeon to give my opinion on what was going on in theatres. Whilst I found those meetings informative they did not change a great deal. Weekly meeting also took place between theatre sister, manager, surgeon, anaesthetist and perfusionist to discuss day to day problems, including the punctuality of surgeons. This was a big issue because we would bring a patient into theatre, anaesthetised. They would then be prepared for surgery by the registrar ready for the consultant surgeon to put them on bypass. However, there would sometimes be a long wait before the Consultant arrived which I felt was dangerous. Mr Wisheart was the main offender, Mr Dhasmana would usually come when he was asked.

Issue B6: Protocols and guidelines to assist clinical decision-making and practice

25. There were (and are) theatre nursing protocols regarding procedures carried out and requirements for those procedures to ensure best practice and patient safety. ODA's would consider they work to the protocols also because they are doing the same work that we do. When I was sister at the BRI it was my responsibility to keep the protocol manual up to date and notify staff of any changes to them. I am not sure who wrote the original protocols. Updates would be generated from Theatre User Group meetings.

Issue B7 : Documentation and the maintenance of high quality clinical records

26. A nursing care plan is completed when a patient attends Theatre. The anaesthetic assistant completes the sections relevant to him/her whilst the circulating person would complete the remainder of the care plan. It would then be signed by both the circulating and scrub person when the procedure had been completed. The care plan would be returned with the patient in their notes to ensure the ICU nurses knew exactly what had happened to that patient whilst in theatre. Care plans were in use throughout the relevant period.
27. The care plan is in the format of a check list with boxes for additional comments and I attach a copy of the current care plan to this statement (Annex 2).

Issue B8 : The location of responsibility for (a) staffing levels and staff training; and (b) management and co-ordination of the staff team

28. The levels of staff working in the department were decided by the theatre managers adhering to NATN guidelines. It was the responsibility of the sisters to make sure the staff received adequate training, not just in cardiac theatre skills, but also making sure staff attended fire lectures, resuscitation, manual handling, and health and safety updates.
29. The co-ordination of the staff team was the responsibility of the sister in charge for that day. On occasions when there was no sister on duty, this responsibility fell to the most senior member of staff on duty who would liaise with the theatre manager if there were any issues which they felt unable to deal with. This situation did not arise very often.

Issue B9 : The information made available to referring clinicians and to members of the public, on standards of treatment and care attained at the BRI

30. These issue did not/do not fall within my area of responsibility.

Issue B10 : Complaints procedures available to members of the public, their use and the responses to such complaints by the hospital, Trust or health authority leadership.

31. Complaints were dealt with by management. Apart from providing relevant documentation the sisters were not involved in any discussions between members of the public and the Trust.

Issue B11 : Mechanisms and structures available to staff members to raise, and to secure action upon, clinical or managerial issues of concern to them; and the limitations of such methods

32. Any member of staff was at liberty to discuss any issues which were causing them concern either with the theatre sisters, directly to management, or with their union representative should they feel that necessary. The sisters would endeavour to deal with any clinical problems within their remit such as theatre protocol issues. All other issues would be channelled through the appropriate source. The majority of staff were unwilling to make formal complaints because of concern about job security. In this situation all that can be done is to accommodate that complaint and act upon it as far as possible.

Issue B12 : The culture of the BRI, as expressed in such matters as;

(a) the relative power and status of key individuals or groups such as managers, surgeons, cardiologists, anaesthetists, nurses or professions allied to medicine.

33. The consultants and senior management were considered to be in positions of power regarding the management of the BRI. The nursing staff and other healthcare professionals have no power at all, except for the few individuals who made it to the top in senior management.

(b) the self image and morale of such groups

34. In the 1980's and prior to that, consultant medical staff have always behaved and been treated in a manner which would assume superiority over the other health workers. This situation has improved, but not totally disappeared. Nurses have always found it difficult to air an opinion when unhappy with a medical decision as they were rarely listened to and this then compromised their own position within their working area.

(c) identity and loyalties amongst staff members, whether towards other staff groupings, or to outside professional associations or other societies.

35. Most of the staff are loyal to their profession. Theatre staff who work in a professional manner will always receive the full support of their theatre colleagues and professional associations.

(d) leadership, team-working and communication between members of staff

36. The nature of theatre work makes it essential to work well as a team. However, this was often made difficult by poor communication skills, particularly from some of the members of surgical staff. It was a regular occurrence to be told at the start of the day that we would be cancelling a case due to lack of an ICU bed yet carry on and operate on that patient later in the day. This would cause confusion particularly if staff had been reallocated to other duties.

37. We were often kept waiting for a surgeon to appear in theatre despite several attempts to inform him that the registrar had the patient ready to go on bypass. This sort of behaviour contributed to the list constantly running over session time. I refer to paragraph 25 above.

(e) the responses toward poor performance by a member of staff.

38. If a member of theatre staff was not performing adequately then that individual would be assessed as to what measures were necessary to bring that individual up to the standard required of them in terms of possible retraining, assessment of their state of health, possibly resulting in referral to occupational health. This was rare. The usual reasons for poor performance were more likely to be due to matters outside the department affecting that member of staff. It was occasionally necessary to send the member of staff concerned to occupational health to address their mental attitude at the time. It has been necessary to send people to occupational health and

give them enforced time off work. It would never be left to a stage where a member of staff was being asked to do something they were not able to do. I would advise them perhaps to consider another speciality and would talk to them in a supporting way not related to disciplinary proceedings. The patient would never be left in any danger and I would always ensure that there was back up. A member of staff's poor performance is very rarely due to incompetence.

(f) the attitudes towards patients who complained of poor service or care.

39. Complaints to theatre were usually from nursing staff on the ward to which a patient had been returned rather than from a patient. They usually consisted of pressure sore areas, diathermy burns and occasionally that there was too much noise in theatre whilst the patient was in the anaesthetic room. The last complaint refers to the noise of the theatre being set up for surgery. We always endeavoured to take precautions to avoid these problems recurring.

(g) the attitudes towards staff who complained of poor standards of care and/or towards "whistle blowers"

40. Most of the theatre staff were fully supportive of any member of staff who brought to light any inadequacies in the quality of care being given. Mr Wisheart was our director for a lot of the time. We felt quite intimidated by him although he is very charming. It was difficult to stand up to him and raise criticisms or problems.

H : The split site

41. The split site did not really affect me. As I have said before in paragraph (15) we had all the equipment necessary to perform paediatric cardiac surgery. I cannot comment on ICU.

SIGNED : Kay Armstrong

KAY ARMSTRONG

DATED : 14/4/99

WITNESSED : G. S. Lawton

kym/sr k armstrong statement-19-03-99

MRS KAY ARMSTRONG

ANNEX 1

SDU
~~away~~
stone
room

Refusion
room

COFFEE
ROOM
NON
SMOKING

DAY SURGERY WARD

MAIN THEATRE CORRIDOR

FIRE EXIT

SDU OFFICE

TH I
ANAES
ROOM

TH I

SCRU8

TH II

THEATRE
II
ANAES
ROOM

THEATRE
III
ANAES
ROOM

SCRU8

TH III

SMOKING COFFEE RM

MEN'S CHANGING ROOM

FEMALE CHANGING
ROOM

ANAES STORE ROOM

KITCHEN

OFFICE

SDU
DIETRY
ROOM

HATCH

SLUICE

PANEL
TH I

SDU
clean
area

Autoclaves

PANEL
TH II

BACK CORRIDOR



MRS KAY ARMSTRONG

ANNEX 2

UBHT

OPERATIVE NURSING PLAN/INFORMATION SHEET

ADDRESSOGRAPH	PRE OP ASSESSMENT CHECK LIST	
	Ward	Theatre
DATE:	1. CONSENT FORM COMPLETED:	
ALLERGIES:	SIGNED:	
PRE-MEDICATION & TIME:	2. I.D. BRACELET & UNIT NUMBER	
NIL BY MOUTH FROM:	3. SITE MARKED	
DENTURES: (loose, capped, crowned)	4. SITE SHAVED	
DENTURES: removed /with patient	5. JEWELLERY REMOVED/TAPED	
GLASSES/HEARING AIDS: removed/with patient	6. CONTACT LENSES REMOVED	
	7. ALL LAB RESULTS WITH PATIENT	
	8. RADIOGRAPHS WITH PATIENT	
	xrays, mammograms, IVPs, arteriograms, etc	
	9. E.C.G.	
	10. ADDRESSOGRAPH LABELS	

BASELINE VITAL SIGNS: B/P: PULSE: TEMP: RESPS:

MANUAL HANDLING RISK ASSESSMENT

SKIN CONDITION: WEIGHT:

INTACT: Y/N if N please specify & add details: HEIGHT:

DEHYDRATED: ANY WEAKNESSESS: please specify

BROKEN: MANUAL HANDLING PROBLEMS: please specify

LESIONS: WATERLOW SCORE:

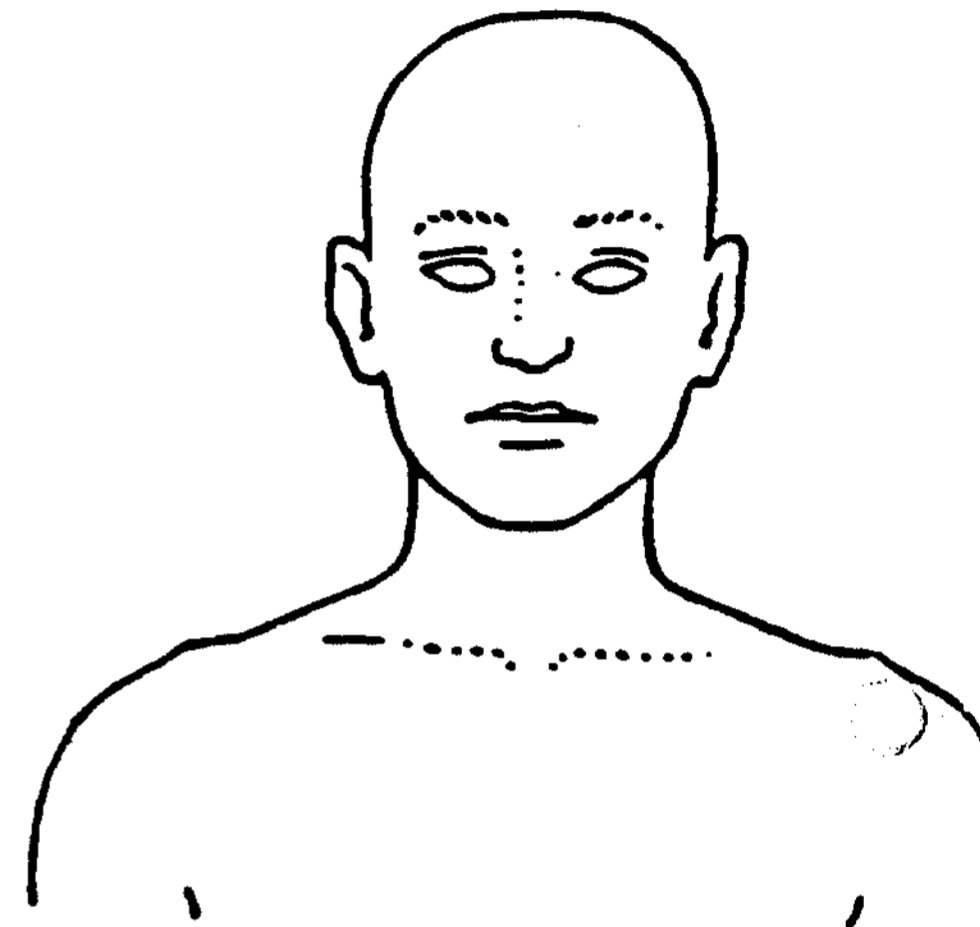
ADDITIONAL INFORMATION eg psychological status, relatives, etc.

WARD NURSE NAME:	THEATRE NURSE NAME:
SIGNATURE:	SIGNATURE:

DATE:	THEATRE No:	ANAESTHETIST:	ANAESTHETIC NURSE:
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ANAESTHETIC:	MONITORING:		*	A	T
GENERAL ANAESTHETIC	ECG		A		
LOCAL ANAESTHETIC	NI B/P		B		
REGIONAL ANAESTHETIC	Sa O ₂		C		
ET TUBE CUT TO:	CAPNOGRAPH				
AIR IN CUFF:	ARTERIAL LINE		D		
TUBE LUBRICATED WITH:	CVP		E		
LUBRICATING JELLY	TEMPERATURE PROBE		F		
LIGNOCAINE GEL	NERVE STIMULATOR		G		
CORDS SPRAYED WITH:	POSITION OF IVI				
.....	1		H		
EYES TAPED	2		I		
POLYFAX OINTMENT	3		J		
ANY OTHER RELEVANT INFORMATION:					
.....					

Please record letters marked * on diagrams



PATIENT TRANSFERRED VIA:					PATIENTS POSITION:
EASY SLIDE	In	Out			SUPINE
LATERAL TRANSFER BOARD					LEFT LATERAL
OTHER PLEASE SPECIFY:					RIGHT LATERAL
.....					PRONE

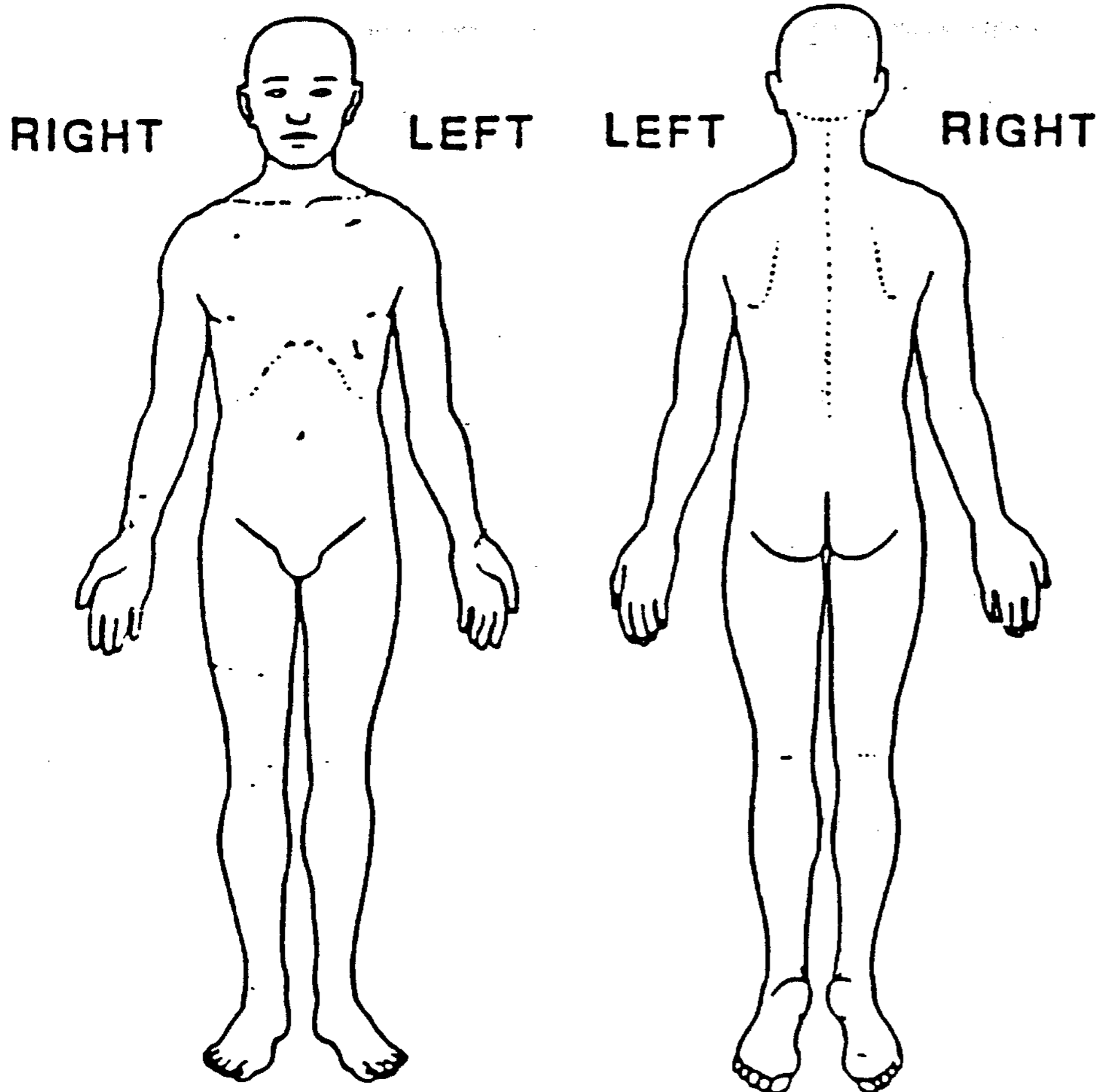
PATIENTS BODY TEMPERATURE MAINTAINED BY:					PATIENTS POSITION:
WARMING BLANKET					LITHOTOMY
SET AT: °C					LLOYD DAVIES
SPACE BLANKET					CHAIR
BUBBLE WRAP					JACK KNIFE
BLANKET					BUNNY RABBIT
OTHER PLEASE SPECIFY:					TRENDELENBURG
.....					REVERSE
					TRENDELENBURG
					HAWLEY TABLE
					SUPINE WITH
					STEINMAN PIN
					LATERAL WITH
					STEINMAN PIN
					OTHER PLEASE SPECIFY:
				

DEVICES USED:	*
SANDBAGS	K
PILLOWS	
D' PILLOW	L
CUSHIONS	
FOAM	
GAMGEE	
LAT. SUPPORTS	
BODY STRAPS	
NEURO HEAD PIECE	
BRADFORD SLING	
HAND TABLE	
HEAD RING	
TIBIAL NAILING ATTCHMENT	M
FOOT PIECE	
OTHER PLEASE SPECIFY:	
.....	
.....	
.....	

RT	ARMS	LT
	ON ARM BOARDS	
	BY SIDE	
	ACROSS CHEST	
	HAND TABLE	
	PROTECTED WITH PADDED	
	ARM SUPPORTS	
	OTHER PLEASE SPECIFY	
	
	
	

OPERATION PERFORMED:
.....
.....
.....
.....

SURGEONS:.....	SCRUB NURSES:.....	CIRCULATING NURSES:.....
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DIATHERMY:	
MONOPOLAR.....	
BIPOLAR.....	
DIATHERMY PLATE.....	* X
SITE SHAVED.....	
TOURNIQUET:	
1. PADDED LIMB	
TIME UP.....	hrs.
TIME DOWN.....	hrs.
PRESSURE.....	mmHg.
2. PADDED LIMB	
TIME UP.....	hrs.
TIME DOWN.....	hrs.
PRESSURE.....	mmHg.

SKIN PREPARATION:		SPECIMENS:			IMPLANTS:
CHLORHEXADINE.....		MICROBIOLOGY.....	No.	sent	
RED STAINING.....		HISTOLOGY.....			
NON STAINING.....		FROZEN SECTION.....			
BETADINE.....		F.W.L.B. (xray).....			DRESSINGS:
<input type="checkbox"/> AVASEPT.....		OTHER PLEASE SPECIFY:.....			
OTHER PLEASE SPECIFY:.....					
URINARY CATHETER:	size	DRAINS:	No.	sent	ANY OTHER RELEVANT INFORMATION:
2 WAY FOLEY.....		REDIVACS.....			
3 WAY FOLEY.....		ROBINSONS.....			
SILASTIC.....		WALLACE.....			
CONTINUOUS IRRIGATION.....		MINIVAC.....			
SUPRAPUBIC.....		OTHER PLEASE SPECIFY:.....			
OTHER PLEASE SPECIFY:.....					SIGNATURE OF SCRUB NURSE:
URINE OUTPUT:		SKIN CLOSURE:			
TOTAL.....					
SWABS WEIGHED:		SUCTION :			SIGNATURE OF CIRCULATING NURSE RESPONSIBLE FOR SWAB COUNTS:
TOTAL.....		TOTAL.....			

AIRWAY STATUS: MAINTAINING OWN INTUBATED LMA GUEDAL AIRWAY OTHER PLEASE SPECIFY:	VITAL SIGNS MONITORING: PULSE BLOOD PRESSURE: NI B/P ARTERIAL TEMPERATURE C.V.P.	LEVEL OF CONSCIOUSNESS ON ARRIVAL: CONSCIOUS AT: TIME ARTIFICIAL AIRWAY REJECTED:
SENSORY LOSS DUE TO REGIONAL ANAESTHETIC: NURSE FLAT PROTECT LIMBS FROM INJURY TEST FOR RETURNED SENSATION	RESPIRATORY FUNCTION MONITORED VIA: SaO ₂ RESPIRATORY MONITOR VISUALLY OTHER PLEASE SPECIFY:	O₂ AS PRESCRIBED: AT: VIA: HUDSON MASK NASAL CATHETER LMA T. PIECE
POSITION OF POST-OP LIMB: ELEVATE ON PILLOW CPM MACHINE BRAUNS FRAME TRACTION HIGH ARM SLING ROLLER TOWEL BRADFORD SLING ABDUCTION PILLOW	FLUID BALANCE MAINTENANCE: CHECK INFUSION SITE CHECK DRESSINGS CARE OF DRAINS MONITOR OUTPUT CONT. BLADDER IRRIGATION NASOGASTRIC TUBE COLOSTOMY ILEOSTOMY URINARY CATHETER	PAIN MANAGEMENT ANALGESIA: ORAL IM IV CONT. INFUSION PCA EPIDURAL SPINAL NONE OTHER PLEASE SPECIFY:
SPECIAL MONITORING: LIMB/CSM ARTERIAL NEURO PULSES OTHER PLEASE SPECIFY:		
OTHER INFORMATION:		
		TIME INTO RECOVERY:
RECOVERY NURSE NAME: SIGNATURE:	WARD NURSE NAME: SIGNATURE:	

Janardan Prasad Dhasmana

Response to Mrs Kay Armstrong's Statement

I Janardan Prasad Dhasmana served the Bristol Royal Infirmary and the Children Hospital as a Consultant Cardiothoracic Surgeon from 1st January 1986 to 9th September 1998.

1. I have known Mrs Kay Armstrong from the time she joined the cardiac operating theatres in 1984. She has outlined her period of service in the paragraph 2.
2. I have gone through her statement relating to issues B and H. as this deals entirely with the management issues concerning operating theatres that I do not have any particular rebuttal comments. However I would wish to make few comments on her statement at paragraphs 24, 36 and 37 which concern me.
3. In the paragraph 24 (page WIT0132 0009), she states "Mr Dhasmana would usually come when he was asked". I feel that this is a vague statement and may impart unfairly on me. In cases of complex and other major paediatric operations and in all emergency operations, I would always be waiting for the patient to arrive in the theatre from the anaesthetic room I would start the operation myself, rather than called at the time, "ready to go on bypass " as she calls it in the paragraph 37 on the page 0014. However, during many routine adult operations, some paediatrics like A.S.D. and isolated V.S.D. and few other paediatric operations in older children the senior or experienced Registrar would start the case and I would then be called in when it was ready to go on bypass. I would like to add that this is a common practice in adult cardiac surgery amongst cardiac units in the UK.
4. In the paragraph 36 (page 0014), she talks about the poor communication skill particularly from some members of surgical staff. She cites the example of the cancellation of cases and the state of uncertainty on some occasions leading to confusion. I would like to explain that members of medical and nursing staff in the

cardiac unit take postponement and cancellation of operation very seriously and would try their best to avoid it. As a result, on many occasions, these decisions used to be delayed to the last moment. Usually, the cancellation would occur because of lack of ITU bed and/or shortage of trained nurses in ITU or operating theatres.

5. The ITU bed could not be promised on few occasions because the patient was still intubated or needed some further tests or observations before being transferred out of ITU. So although the theatres were warned of impending cancellation, the anaesthetist/intensivist and senior member of surgical staff would still go around the ward later in the morning to reassess the patient and make final decision. On many occasions it was possible to make a bed available and proceed with the operation. Similarly, in cases where the cancellation was threatened due to acute shortage of nurses, mainly due to sudden illness, the nurse in charge of ITU may take few hours to find the replacement, usually by readjustment amongst the shift and/or with the help of locum agency. I regret that Mrs Armstrong feels that this caused confusion but this happened because of our sincere effort to avoid cancellation of operation for some of these very sick patients.
6. The above statement is correct to the best of my knowledge and belief.

Signed: Janardan Prasad Dhasmana

Date: 3 August 1999