

The BRI Inquiry into Paediatric Cardiac Surgery in Bristol (1984-1995)

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Introduction

1. This statement is made in response to the Inquiry's request for information on "Block 4". I make reference to my earlier statement dated 24 June 1999, which dealt with Issues B and H. There may be some overlap with the remaining issues being addressed in this statement.

Issue C: The Service Provided: Nature and Outcomes

2. I had no involvement in clinical or nursing matters at the BRI and can make no comment on this issue.

Issue D: Referrals

D2 The judgement or impression formed by referring paediatricians or other clinicians of the paediatric cardiac surgical services provided by the BRI.

3. I cannot comment on the impression or judgement formed by referring paediatricians of the paediatric cardiac surgical services provided by the BRI. From a nursing perspective it was a general principle that it was better if children were nursed in a children's setting. However, it was accepted that the relevant clinical expertise for open cardiac surgery was at the BRI at that time.

Issue E**E1 The arrangements and services available to manage the transfer of sick children from referring hospitals to the BRI.**

4. If surgery was taking place electively at the BRI then pre-operatively children were not usually first admitted to BRHSC. Very few children were in-patients at BRHSC before undergoing surgery at BRI. I do not know what arrangements may have been made for transferring children from elsewhere in the region to Bristol.
5. Where children were transferred from BRHSC to the BRI, then this took place with an appropriate staff escort as well as family members. There was always a nurse escort, and there would also be a medical member of staff if this was deemed necessary.

E2 Where children were managed pre-operatively; and under which clinical speciality.

6. Pre-operative investigations took place at BRHSC under the care of the paediatric cardiologists. When the investigation results were received the child and parents would then meet with the consultant paediatric cardiologist at an out-patient appointment to discuss the results.

This outpatient appointment may have been at the BRHSC or at a peripheral clinic closer to the family's home.

7. Children admitted for pre-operative clinical investigation were generally admitted to the medical wards at BRHSC. The choice of ward was influenced by bed availability and the child's age. There were 2 medical wards, of which one (31) was predominantly for oncological treatment, the other, a more general Ward (36). Young babies were admitted to the Baby Ward (37).

E6 The organisation and management of theatre lists.

8. I was not directly involved in the organisation or management of theatre lists. Cardiac catheter sessions were available at BRHSC from 1987. When the cardiac catheter laboratory transferred to BRHSC in 1987 it seemed to me that there was less difficulty in arranging for children to be booked in, as the need for liaison with the catheter lab at the BRI to book in such sessions had vanished. I was not directly involved in the booking in of such sessions. I do not know whether there was any limitation or problem in booking catheter sessions, although they did require transfers to/from the BRI. At ward level at BRHSC, we were simply advised that a child was being admitted and given details of when the cardiac catheter was arranged to be undertaken.

E7 The mechanisms in place in order to ensure that surgery (whether elective, urgent or emergency) took place at a time regarded by the clinicians at the time as clinically optimal or appropriate.

9. The assessment of a child's condition and decision to operate was made by the clinicians. If necessary the child's case was listed for theatre. I do not know whether this took place at the clinically optimal time or whether this was simply the best that could be obtained.

E8 Whether operations (particularly elective ones) were carried out at a time regarded by the clinicians in charge of the child's care as appropriate; or whether the timing of operations was affected by matters such as limitations in the number of beds available in the ICU, availability of nursing staff or other staff, or the requirements of adult cardiac surgery.

10. There were clearly other factors that influenced the timing of (closed heart) operations at the BRHSC. I do not know how often other factors did cause a problem or affect the scheduling of an operation in practice. I cannot comment on the scheduling of operations for open heart procedures at the BRI, although I would

expect that the same general principles must have applied.

11. There were times when procedures had to be cancelled due to staff shortages. This is a general comment about procedures and not limited to cardiac surgical procedures. If the available skill mix was insufficient to ensure patient safety then procedures had to be cancelled. This is equally true today, and factors such as availability of nursing staff, skill mix and limitations in the number of beds can still affect the timing of operations.
12. In respect of cardiac surgical procedures it was necessary to know beforehand that post-operatively there would be an ICU bed available, with appropriate staffing, particularly where the procedure was an elective one.

E9 If there were delays in surgery, the effect (if any) of such delays upon the outcome for the children affected.

13. I cannot comment on this as I do not know what the effect of any delay might have been on the outcome of children affected. I was certainly aware that it was very inconvenient if surgery was cancelled, and stressful for the children and parents affected, and never a decision taken lightly.

E15 Liaison of staff with parents; and the participation of parents in the assessment and care of their child.

14. Parents were usually resident and present on the ward for a significant amount of time. Procedures were explained by nursing staff. The philosophy was very much to involve parents and explain the procedures that would be taking place. During discussions with parents I was aware that medical staff often drew pictures of the heart, indicating abnormalities and showing techniques that would take place when an investigation was carried out. It was readily acknowledged that to see the problem and to have it explained facilitated understanding. Most parents appeared to appreciate this approach.

15. I cannot recall any complaint from a parent about a lack of involvement or of a failure to inform them about an operation. I believe I would have been aware of such a complaint at the time. This is true of all children's care and not simply those admitted for cardiac investigation.

16. I received and dealt with complaints of a "housekeeping" nature, but do not recall seeing complaints about nursing care or management.

Issue G: Post-Operative Care

18. I was not involved in PICU and so I cannot comment on this issue.

Issue I: Treatment of Families, including the Bereaved

I1 The nature, extent and adequacy of the services that were established to inform, support and counsel families with children receiving surgical cardiac care at the BRI, whether before, during and after surgery.

19. There was a social work department based in the BRHSC, to which parents were referred, if appropriate. Referral was usually in respect of basic needs, such as assistance with travel. Referred parents were allocated a support worker.
20. Helen Vegoda was available as a cardiac counsellor from 1988 to 1996. Nursing staff undertake a certain amount of counselling training in their initial nurse training and have access to counselling courses post registration. It was seen as part of nursing duties for nurses to support and counsel families with children receiving surgical cardiac care at BRHSC.
21. The training department ran a specific course for nursing staff entitled "Talking to Relatives" from 1984. This was a popular course because it was very relevant. It was useful in giving nursing staff confidence to carry out techniques in front of relatives and explain what was happening.
22. Nursing staff also saw it very much as their role to explain if required what medical staff had said about a patient's treatment at any stage of their admission. It was the nurse's function to support the family sympathetically, and to enhance their understanding where this was required. Paediatric nurses were and are very aware of the needs of the family at such a time. They are there to support the family as well as the child, but recognise the limitations of their own knowledge and experience. Less experienced staff would refer to more senior colleagues if necessary.
23. BRHSC always had a chaplain, who was Church of England. If families wished, they would be referred to other religious bodies. There is also a chapel at BRHSC.

I2 The nature, extent and adequacy of the services that were established to inform, support and counsel families with children who died or suffered permanent disability after receiving cardiac care at the BRI; including liaison with community and social services.

24. From approximately 1980, the training department ran a 2 day counselling course and a 5 day course entitled "Caring for Dying Children" for nursing staff. The longer, more advanced, course took place once a year and was facilitated by Sally Curnick who was a CLIC funded oncological community nurse who had a lot of experience with that client group. She was also assisted by Anne Harris who was a Malcolm Sergeant funded social worker. This course taught the holistic approach to the child, and the wider input needed for families. It was run specifically for children's nurses, although it was not specific for oncological or cardiac patients. The course taught general principles which covered all situations where care for the dying child was needed.
25. In general terms, Sally Curnick was, and still is, a very useful resource. She can be accessed if there is a particularly difficult situation and a nurse does not know how best to deal with it. Sally is available and approachable.
26. I refer to my response to Issue I1 above. If it was anticipated that a child was going to die, parents were asked if they wanted nursing staff to contact anyone. If they wanted the chaplain, then he would come to the bedside. If the family was local then the local chaplain may have come in if that was preferred. If the parents wished it, the child could be baptised on the ward. The wards had the necessary equipment for this.
27. Parents could stay with their child for as long as they wanted to after death. If families wished to take footprints, handprints, or a lock of hair, then nursing staff arranged this. Where appropriate photographs could also be taken. After this the child was moved to the Chapel of Rest. If families wished to visit the child after

- this time, a member of nursing staff escorted them to the Chapel of Rest, and stayed with them during the visit to provide support and answer any questions.
28. The Chapel had a book of remembrance which was open for people to write in as they wished.
 29. Some wards continued to contact the bereaved family, and would send a note or card on the anniversary of the child's death. In more recent years there has been an annual remembrance service for children. Parents are contacted and advised that the service will be taking place.
 30. If a child was permanently disabled then he or she would be an in-patient for a longer period. If the child had had open heart cardiac surgery at the BRI then it was likely he or she would have been transferred to BRHSC. Community paediatricians would have been involved, although this was very much influenced by where the child lived. Until recent times there has been one community paediatrician, Dr Alan Emond, employed by UBHT. I am not certain when he joined the Trust.
 31. There was liaison with social services and with many other professions such as education, paramedics, physiotherapy, dietician, and all other specialities involved in the assessment of home management. Co-ordination was mainly carried out by the social worker concerned. Nursing staff liaised with the social worker about equipment needed for home management, and made an active contribution with suggestions.
 32. Nursing staff also liaised with the primary health team about nursing care required. For example, medication and tube feeds. If tube feeds were necessary, either nursing staff taught parents how to do them, or they liaised with whoever in the primary healthcare team was managing the child at home. Nursing staff were involved in obtaining the appropriate equipment for home management, and obtaining ongoing supplies as required.

I3 The financing of the support and counselling services.

33. Social workers were funded by social services. The counsellor was hospital funded to the best of my knowledge. I do not know if any charitable monies were involved.
34. I am aware of the existence the South West Heart Circle. BRHSC benefited greatly from their support. I did not have any direct dealings with the South West Heart Circle. I only have a general knowledge that they carried out some extremely valuable work.
35. I am unaware of any assessment that support for the counselling services was anything other than adequate. Certainly I was not aware of any perceived shortfall in this service, or any indication that there was a need for additional funding.

I4 The priority afforded to support and counselling work by hospital management and clinical staff.

36. From a nursing perspective I believe support and counselling work was considered a high priority. Access to post-registration courses, although limited, has always been available and supported by hospital management. I am less aware of the priority given to this by medical staff.

I5 Whether staff coming into contact with parents who were under stress because of the nature and severity of their child's condition, or who had lost children, showed appropriate sensitivity in their dealings with such parents; and, if not, the importance and effect of any such failures.

37. It is an integral part of nursing to adopt a holistic approach to support the family of a sick child or the bereaved family. On a day-to-day basis physical care might be a priority and this might affect time available to support families, but nursing staff were very aware of the need for such support. If a need was identified, but workload meant that nursing staff did not have adequate time, then nursing staff

knew where parents could be referred and who could be involved.

38. I believe nursing staff approached their dealings with families with sensitivity to the best of their ability. The death of a child was always viewed as a regrettable event and would take priority over other issues. Support of parents who had lost their child was a priority. Someone, usually the most senior nurse, would be assigned to be with the parents, so they were not left alone, no matter what the pressure was on the ward at the time.
39. Again, if there had been any complaint about a nurse approaching parents with a lack of sensitivity then I believe I would have heard about this. There was no such complaint to the best of my knowledge.

Issue J: Post-Mortems and Inquests

J1 The nature and extent of the responsibilities of (a) hospital staff; (b) hospital pathologist; and (c) HM Coroner to report and investigate deaths.

40. The responsibility lay with medical staff to refer a death to the Coroner. I believe nursing staff had an understanding of what was an appropriate case to be referred to the Coroner, but the decision was a medical responsibility.

J2 The functions of post-mortems and inquests in helping to establish the cause of death of a child or the adequacy of the surgical or other services provided.

41. I have no information to offer on this.

J3 The extent to which post-mortems and any inquests held upon children who died following complex cardiac surgery at the BRI performed such a function.

42. I have no information to offer on this.

J4 Whether consent (if required by law) to:

(a) hospital or coronial autopsies; and/or

(b) the retention of tissue and/or organs of the body

was properly and sensitively sought; and, if consent was not required, whether proper and adequate information about this matter was given to parents, in an appropriate fashion.

43. Consent was obtained from the parents by the doctor concerned. A nurse might be present, but not necessarily. If consent was required then there was a standard consent form in use. Nursing staff knew where to find a consent form and would have it to hand if needed.

44. There were occasions when nursing staff had input, where a patient asked a nurse to

provide clarification or explanation of what had been said by the doctor.

Issue K: Training and Retraining

K1 The support and assistance made available to all members of staff, to help them keep abreast with developments in clinical practice; and the use made of such facilities.

45. New staff underwent an orientation programme on arrival at BRHSC. I participated in this orientation, meeting with the nurse, as the senior nurse for the Unit. The orientation programme varied from ward to ward, depending where the nurse's previous experience lay. The purpose of the orientation was to introduce the nurse to the new building and environment. Clinical orientation depended on the nurse's previous experience. For example, if the nurse was previously trained and assessed as competent in the giving of IV drugs, then their need for additional training would be different to that of a newly qualified nurse.
46. The orientation programme was planned by the ward sister or manager. It would simply be part of the orientation to meet with me. I may have been involved in providing other aspects of the programme i.e. a practical session on administration of IV medication.
47. For the staff I managed, that is the ward managers, I planned their orientation programmes, and determined how long the orientation programme lasted. For the majority of staff, the ward sister made an assessment of their competence and confidence, and would respond to any further training needs identified. This may have been, for example, to book a place on the next "Talking To Relatives" course.
48. Information about training courses was fairly freely available. I was one source of information. If I received details of a course from the training department I would pass that on to the ward sisters. In-house training was pre-funded in the sense that there was an allocated number of places on each course. If an application was made for a place on a course within the appropriate period, and within the hospital's allocation, then the place was confirmed. If there was an application for an external

course then the availability of funding influenced whether the individual could be supported to attend. Obviously it was not always possible to do so.

49. Training covering nursing clinical issues was largely dealt with in-house. External training related to wider issues where, for example, attendance at a national conference was desirable to give a national perspective or for very specialised services where local experience/knowledge was limited because of the size of the service i.e. management of CF patients.
50. Application to attend training was a formal process. The individual and ward sister would identify the need for training, for example, the giving of IV drugs, and then the application for the nurse to attend the course was made. The application would come to me as line manager and then I would pass this to the Training Manager for the Trust. This process required me to 1) endorse the individual's application i.e. that he/she met all the necessary criteria to undertake the specific course and 2) to prioritise, whenever demand exceeded the available places for a course, and 3) to co-ordinate/monitor attendance to maintain a staff profile of training/skills.
51. If a surgeon introduced new surgical procedures and other members of staff needed to be aware of any implications, then the medical staff trained those who needed to know. Such training might include a company representative if, for example, it related to a new piece of equipment. If new equipment was to be used then company representatives were very good about training, and offered flexible training sessions, so as to ensure that as many staff as possible had an opportunity to attend.
52. For a procedure with clinical implications which was not purely a nursing matter as I have referred to above, then liaison took place between medical staff and ward staff. If a significant change was proposed, I liaised with nursing staff at other centres who had experience of the new procedure. For example, in respect of the introduction of patient controlled analgesia pumps, we communicated with other hospitals when considering the nursing protocols. This was carried out in liaison

with the relevant company representative. I do not recall any exclusive change in cardiac practice giving rise to specific training issues.

53. To my knowledge there has always been a staff appraisal system. The ward manager reviewed nursing staff on the ward. I reviewed the ward manager. My manager carried out my review. The process has changed over the years, developing into more of a reflection of the individual's performance, with the emphasis on preparing an action plan for the next 12 months. This action plan identified any further responsibilities to be assumed, and associated development and training needs. The appraisal might address any perceived area of weakness, but the focus was on development and meeting any need that was present.
54. It was well understood that any concerns about an individual's performance needed to be raised immediately and not kept to be addressed as part of a routine appraisal. Therefore, appraisals were about reflection and positive planning for the future, rather than new concerns or criticisms being brought to the individual's attention. If it was perceived that a member of nursing staff was in difficulty in respect of any aspect of her nursing then it would not be left until her next appraisal before being raised. For example, if it was felt that someone was unhappy adopting a counselling role, then that nurse would be fast-tracked for the appropriate counselling training course.
55. Another very popular course was entitled "Teaching in Work" provided by the staff training department from approximately 1980. This was also accessed frequently by nursing staff.
56. Nursing staff also learn on the ward through the role model of their colleagues and practical experience. It was recognised that a lot of the practical skills were developed at ward level and not through the attendance at theoretical courses.

Issue L: Informed Consent

57. As a manager, I understood that consent was obtained by medical staff in an informed way although I was not involved in the process. I knew which procedures needed consent and was aware that different forms were available.
58. My only involvement in the issue of consent might occur if there was a problem. For example, if a child needed to go to theatre and no parent was available to give consent, or if the child was a Jehovah's Witness and the parent refused to give consent. On these occasions I would act as an available resource, in trying to contact parents, or by obtaining legal advice for example. I did not have any involvement in the general process of obtaining consent.
59. Nursing staff may or may not have been present when the doctor obtained consent. A parent might seek clarification from nursing staff, in which case information was provided by way of explanation or clarification in a supportive role. The nurse may well ask the doctor to return to speak to the parents again, if it was thought helpful to aid this understanding.

Issue M: Review of Cases and Medical and Clinical Audit

60. I have no information about medical and clinical audit in the sense as set out in this issue. I had a general awareness that morbidity/mortality was being discussed in other areas, but I was not aware of any analysis unless it brought in management issues, such as the need for more money or resources. I cannot recall any audit issue arising in respect of cardiac surgical procedures.
61. My own attendance at medical or clinical audit meetings did not commence until approximately 1991/1992.
62. In general terms, there were national recommendations against which the service could be benchmarked. For example, the national recommendation was made that 2 children's trained nurses be on duty per shift where children were being nursed. (Department of Health Welfare of Children and Young People in Hospital 1991.) Fairly soon after this report was published I carried out a staffing profile to see how we fared against this benchmark standard. Generally as a hospital, BRHSC met this standard well, as I recall, although I have not been able to locate the report.
63. I was involved in the monitoring of complaints. All complaints were acknowledged and investigated. As a result some action might be triggered or a trend might be picked up. Most complaints were about "housekeeping" issues, such as availability of residential accommodation and hospital food, and not clinical care. I do not recall any complaint about medical/nursing care in relation to paediatric cardiac services.
64. Incident forms/accident forms were also a means of reviewing how wards were performing. For example, if there was a run of needlestick incidents, or children tripping over, then this was discussed with nursing staff and might identify the need for further equipment, or a training need. Again, I do not recall any incident forms/accident forms highlighting any need for equipment or training in relation to cardiac procedures.

Issue N: The Expression of Concerns

65. I have no information about this.

SIGNED :

BARBARA SHERRIFF

DATED :
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