

The BRI Inquiry into Paediatric Cardiac Services in Bristol 1984-1995

Name	Alisa Jane HALL
Address	Bristol Royal Hospital for Sick Children St Michael's Hill Bristol BS2 3BJ
Occupation	Senior Staff Nurse, Paediatric Intensive Care Unit (PICU)

Introduction

1. This statement is made in response to the Inquiry's request for information relating to evidence to be heard in "Block 4". My comments are confined to my 14 months experience gained on the Paediatric Intensive Care Unit (PICU) at the Bristol Royal Hospital for Sick Children (BRHSC) during the relevant period. I am unable to comment specifically on issues relating to the Bristol Royal Infirmary.
2. I trained and qualified at the BRI, gaining my RGN in 1986 (my general nursing qualification). I attach my employment record as **Annex 1**, identifying the posts I have held between October 1986 and the present. I obtained my ENB 100 intensive care nursing of adults in 1990. This included a 6 week placement as a student nurse on Ward 5 at the BRI, on which paediatric and adult cardiac surgery patients were nursed. I gained my children's nursing qualification in 1996 (RN Part 15) and ENB 415 paediatric intensive care nursing qualification in 1998.
3. I started work at the BRHSC in April 1994 as an E Grade Staff Nurse on the PICU. When I joined I had a great deal of adult intensive care experience, but had very little experience in caring specifically for children. I gained experience in caring for children during my orientation period at the BRHSC, and then through ongoing teaching afternoons and in post training. I held this position until June 1995, when I spent a year studying for the RN Part 15, gaining a diploma in Children's Nursing. I returned to the Unit in June 1996, becoming an F Grade Senior Staff Nurse in April 1997. By the time I returned to the Unit in 1996, the paediatric cardiac surgical service had transferred from the BRI and was well established at the BRHSC.

Issue B: The structure of paediatric cardiac surgical services at the representative sites at the BRI and BRHSC, including:

B1a: the services offered;

4. The BRHSC PICU provided care for critically ill children and their families. Children were sometimes cared for pre-operatively before being transferred to the BRI for surgery. If a child required prolonged intensive care treatment after surgery at the BRI, then they might be transferred to the BRHSC PICU, so as to alleviate the pressure of bed space at the BRI cardiac ITU for post-operative surgical cases. I do not now recall if a specific time scale was indicated for this decision.

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

5. PICU today has a different management structure because the number of beds available has increased and there are more nursing and medical staff. I don't remember the specific management structure in the relevant period.

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

6. I had no involvement at that time with management issues. Now, as an F Grade nurse, I have nursing responsibility for the unit in the absence of a G Grade, as the most senior nurse on duty.

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);

7. I have no information on this issue, as staffing was (and is) the responsibility of more senior nurses. As a senior staff nurse since 1997, I am responsible for planning the off-duty rotas for the Unit, which includes interviewing and recruitment.

B1g: regulatory and disciplinary structures;

8. I am aware of the UKCC code of professional conduct for nurses, and that there is a Trust disciplinary policy. I have never had to invoke or been involved in either procedure.

B1h: counselling and support for staff;

9. I believe that there is a counselling service in UBHT through Occupational Health but I do not know any details. I do not know what was available during the relevant period. I have never needed to use or find out about the service for another member of staff.

B1i: relationship with University of Bristol and other academic centres;

10. I have no information on this issue.

B1j: key managers and clinicians: identities, powers and functions, collaboration between disciplines;

11. In general, nursing staff in intensive care units have traditionally had far more say in patient care than in ward based nursing. Ward rounds in PICU are multi-disciplinary and everyone has their say. Nurses of all grades are listened to, because it is they who are providing 24-hour care. In my experience, collaboration between disciplines is extremely good.
12. Prior to the move of paediatric cardiac surgery from the BRI to BRHSC, PICU was a small 5-bedded unit. There were 4-5 Consultant Anaesthetists who rotated through the Unit. At that time, few paediatric cardiac surgery patients were on PICU. The paediatric cardiologists had a major input into paediatric cardiac care, but it was the intensivists who managed day-to-day care.

Issue C: The Service Provided: Nature and Outcomes

13. I am unable to comment on this issue as it relates to paediatric cardiac surgery, as this took place at the BRI during the relevant period. As a student nurse on Ward 5 for only 6 weeks, I had insufficient experience to make any judgements about this issue.

Issue D: Referrals

14. I am unable to comment on this issue, as I was not involved in the referral process, save to say that I was aware that some of the babies who were in the BRHSC PICU were sometimes referred to Birmingham. I am not sure why this was, but I think they were referred elsewhere because they needed urgent surgery and the surgeons at the BRI were either on holiday or were away for other reasons. This still happens today. They may have also been referred out of the area if they needed to undergo more complex procedures, although I cannot be definite about this.

Issue E: Pre-Operative Management of Cases**E1: The arrangements and services available to manage the transfer of sick children from referring hospitals to the BRI.**

15. I was never involved in the transfer of children from the BRHSC PICU to the BRI. I was aware that children were transferred to Ward 5 of the BRI prior to surgery. I recall that I looked after children prior to their transfer to Ward 5, but I was not directly involved in their transfer. This was probably because I was not on duty when they transferred to the BRI.
16. I recall that a small number of children stayed in the PICU for as many as 5 weeks. I believe that this was because they were newborn babies and that surgery should be postponed until they were bigger.

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

17. As I recall children were managed pre-operatively by the paediatric cardiologists. The children would either stay in the PICU or in Ward 37, of BRHSC, depending upon how ill they were before transfer to Ward 5 at the BRI. If they were at home, they would be admitted directly to Ward 5 of the BRI.

E3: The re-assessment of the clinical condition of children admitted for elective surgery, following admission.

18. Again as I recall, the children were looked after by the paediatric cardiologists at the BRHSC. The PICU team had an input into the child's reassessment, but the final decision lay with the cardiologist under whose care the child was. I cannot comment on reassessment at the BRI.

E4: The manner in which decisions to recommend surgery for a child were discussed between paediatric cardiologists and paediatric cardiac surgeons, and other members in the cardiac surgery team; and the means by which such decisions were taken.

19. I am unable to comment on this issue.

E5: Who bore the ultimate responsibility of deciding whether and what surgery was appropriate for a child, who would perform it, and when it should take place.

20. I am unable to comment on this issue.

E6: The organisation and management of theatre lists.

21. I am unable to comment on this issue.

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.

22. I am unable to comment on this issue.

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.

23. Surgery for patients on PICU awaiting transfer to the BRI could be delayed due to a lack of ICU beds on Ward 5. This was sometimes inevitable as one can never predict accurately a surgeon's workload or how long a particular patient will need to remain in intensive care. An emergency may arise where the surgeon has to operate, which means that the ICU bed allocated for the child awaiting elective surgery is used by the emergency case. From my recollection, the delay in surgery was generally less than 1 week, and there was generally no adverse outcome anticipated in such a short delay to elective surgery. I do not know how decisions were made, in terms of which patients were postponed.

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

24. Please see my comments at paragraph 23.

E10: The qualifications, training, experience and skills of the paediatric cardiologists.

25. I am unable to comment on this.

E11: The service provided by paediatric cardiologists in diagnosing or describing:

- a. the structure and anatomy of the child's heart and lungs;
- b. the clinical condition of the child;
- c. the nature of the surgical procedure required, and any complications that might be encountered by the surgeon;
- d. the speed or urgency with which any intervention was required.

26. I am unable to comment on this.

E12: The protocols or clinical guidelines, machinery, equipment or technical services (e.g. radiological interpretation) available to cardiologists to assist them in this task.

27. I am unable to comment on this.

E13: Pre-operative assessment and preparation procedures, including meetings at which treatment and operations were discussed and planned.

28. At the BRHSC, nurses were not involved in meetings where a child's operation and treatment was discussed, unless the child's parents were also at the meeting. In those meetings the nurses attended so that they would be able to re-explain and answer any points on which the parents wanted further clarification after the meeting had ended. If there was a point then raised by the parents that the nurse could not answer, the query was passed to one of the paediatric cardiologists. In this way the question would be answered fully and relatively quickly, directly by the cardiologists talking again to the parents on the next daily ward round or sooner.

E14: Pre-operative observation, assessment and care by the nursing staff and other professions (such as physiotherapists).

29. The nurses provided the care the child needed, as directed by the paediatric cardiologist and intensivists, so that the child would be well enough to undergo the operation. If parents had wanted to have a look around Ward 5 and meet the staff at the BRI, then this would have been arranged, although I do not recall this ever being requested. Since then, the experience I have had confirms the view I formed then, that the nursing and other staff were very caring and professional.

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

30. There was a lot of liaison between staff and parents whose child was on PICU. Parents were encouraged to participate in the care of their child, as much as they were able, by for example, washing them, changing their nappies and feeding them.

Issue F: Management of Surgery

31. I am unable to comment on this issue, with the exceptions below.
- F3:**
- a. The qualifications, training, experience and skills of all other members of the surgical team (e.g. nurses and perfusionists).**
 - b. The support and assistance given by such members of the surgical team.**
32. I was aware that there were not many, if any, paediatrically trained nurses working on Ward 5 of the BRI. There was a general feeling amongst my peers when I started working at the BRHSC PICU, that this was not perhaps an ideal situation, since the BRI staff were looking after such ill children on Ward 5.
33. However, from my professional experience, as an adult intensive care nurse, whilst it is helpful to have a paediatrically trained nurse available to refer to, it is not necessary to be paediatrically trained to provide effective intensive care nursing of a child or baby as the essential part of the training and experience is in cardiac ITU. The children's qualification certainly gives a greater insight into the psychological impact of surgery, and "rounds off" your experience of caring for children in an ICU environment. This is why I undertook the children's course in 1996.
34. I am unable to comment on part b.
- F6:**
- a. The existence, extent and awareness of any material differences in the manner (including speed) of carrying out surgery at the BRI, when compared to surgical practices current at the time; and**
 - b. the impact (if any) of such factors upon mortality and morbidity rates.**
35. When I first joined the BRHSC PICU, I was unable to make a comparison between the speed of surgery at the BRI and other centres. This was due to my lack of experience of other similar centres. Retrospectively, I feel that some of the babies seemed to wait a long time for their surgery. The service currently provided at the BRHSC offers corrective surgery to babies from birth. My recollection of the relevant period is that babies were not operated on during their early days of life.

36. If a child stayed in the PICU before being transferred for surgery, the nurses would often telephone Ward 5 to find out how the operation had gone. I can recall that there were occasions when the nurses would telephone periodically throughout the day, and sometimes into the evening, to be told that the child was still in theatre. This seemed to me to be quite a long time in surgery, although I was unable to make a comparison and knew that these were very complex procedures. Retrospectively, from my own observations, I now understand that this was a long time for a child or baby to be in surgery. I do not recall this being raised as a concern by any of the staff at the time.
37. I am unable to comment on part b.

Issue G: Post-Operative Care

38. Very few children/babies were transferred back to PICU after surgery at the BRI, so it is almost impossible for me to comment on post-operative care.

G1: The national standards or guidance in existence, in 1984-1995, to shape the organisation, numbers and experience of staff within ICUs such as those of the BRI and the BCH.

39. I had no knowledge of these.

G2: Staffing within the ICUs caring for children following cardiac surgery: numbers, training, experience and skills mix.

40. I had no knowledge of this – it was on Ward 5, BRI.

G3: How, if at all, the skills mix and expertise of the ICU staff differed from both published guidance and the standards and patterns to be observed across the country at the relevant time.

41. I am unable to comment.

G4: The availability of staff throughout the 24 hour day to assess and to meet, following such assessment, the needs of any child in ICU after paediatric cardiac surgery.

42. I am unable to comment as this applied to Ward 5, BRI.

G5: The development and organisation of immediate post-operative care.

43. I am unable to comment as this applied to Ward 5, BRI.

G6: Liaison between specialities, and steps taken to ensure continuity of care.

44. I am unable to comment as I was not working at the BRI.

G7: The assistance provided by paediatric cardiologists. The impact (if any) of the fact that these cardiologists were based in the Children's Hospital, upon the availability of such assistance.

45. I am unable to comment.

G8: The extent to which the demands or requirements placed upon ICU nurses and other staff by paediatric cardiac cases differed from those imposed by adult cardiac cases or other cases commonly encountered; and the steps taken to address any issues that might arise out of such differences.

46. In general, from personal experience, nursing a child at the BRHSC was different from working in adult nursing, in that you are not just looking after the child, you are also looking after and seeing to the needs of the whole of the child's family. I cannot comment on differences in cardiac surgery as I did not nurse adult cardiac patients for any length of time.

G9: The supply and maintenance of proper and adequate equipment to the ICU.

47. I am unable to comment on arrangements on Ward 5. At BRHSC on PICU, every staff member is responsible for reporting faulty equipment. Maintenance is carried out by MEMO, the Trust's engineering department.

G10: The standards and post-operative care delivered at the Infirmary and the Children's Hospital; (including such matters as post-infection rates, and the general standard of hygiene and cleanliness).

48. I observed standards at PICU to be good. I can make no comment on the BRI.

G11: The management of discharge and future care.

49. I was not involved in most paediatric cardiac surgical cases, as children were normally discharged from Ward 5. Those few patients who came to PICU post-operatively, were discharged and followed up by the paediatric cardiologists.

G12: Liaison of staff with parents; and the participation of parents in the assessment and care of their child.

50. Immediate post-operative care was usually on Ward 5, at the BRI. For those children who returned to PICU, the same arrangements applied as pre-operatively (see paragraph 30).

Issue H: The Split Site

51. Parents whose child had stayed in the PICU kept in touch with us and updated us on their child's progress during their stay at the BRI. I recall that they often came back to talk to us if their child had died. My impression was that as their child had been with us pre-operatively we had gained their trust and friendship. They may not have known anyone in Ward 5 at the BRI long enough to develop such a relationship, as they may have only been there a short time.

52. Although there were no complaints regarding the split site and the treatment of care received at the BRI, I recall that some of the parents commented that they were not entirely happy for their child to be staying in a mixed adult and paediatric intensive care unit at the BRI, both before and after surgery.

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.

53. Staff would have to apply for study days in order to be fully trained in bereavement counselling. There was a huge amount of support from colleagues, so that if a nurse felt she would not be able to cope with a particular situation, she could move away and a more experienced nurse would take her place.
54. A counsellor, Helen Vegoda, was available to talk to and support families if they required it, although I do not know how extensively she was involved with the parents.
55. I believe there was a nurse on Ward 5 who acted as a link to the counselling services available. I do not know who she was.

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.

56. I am unable to comment in relation to the BRI. If a child died whilst in BRHSC PICU, a chaplaincy service would be offered. Parents could go to the chapel of rest so that they could spend as much time alone with their child as they needed.

I3: The financing of the support and counselling services.

57. I have no knowledge of this and so am unable to comment.

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

58. I have no knowledge of this and so am unable to comment.

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.

59. I am unable to comment about the BRI. Staff at the BRHSC were, in my opinion, sensitive to the needs of and very good at helping bereaved families. As a new member of staff, if I was looking after a child who was dying and then who did die, I was given support by my colleagues.
60. At the BRHSC, the make-up of the team worked well, so that arrangements could be made for a team member's attendance at the funeral, if a child died. The parents would generally wish for the nurse who had looked after their child to attend the funeral. The member of staff usually wanted to attend, both to provide support for the family and as a result of their feelings for the child who had died.

Issue J: Post-Mortems and Inquests

61. I have no knowledge of this and so am unable to comment.

Issue K: Training and Retraining

62. I have been asked to comment on **UBHT 0127 0014**. This document was usually given to student nurses before their arrival on the PICU. I think there was also other documentation handed out, but I am unable to locate any copies. The ENB 100 course was the general adult intensive care course. I acted as a mentor to the ENB 100 students allocated to PICU.
63. I was appointed as mentor for the ENB 100 course since that was the qualification I had when I joined. It was appropriate for a mentor to be appointed who had already gained the relevant qualification. I would normally mentor one student at a time, and probably see around 10 each year. Students would stay for 2-3 days, or maybe even a week. If my off duty did not coincide with that of the student, I would allocate another member of the team (also ENB 100 qualified) to be with the student when I was unavailable.
64. I believe that students were given the option of which hospital they wanted to attend in order to gain practical experience. Some chose to come to the BRHSC. Not all of them did. I believe that some went to Frenchay Hospital, which has a specialised centre for head injuries, although this was only a short placement.
65. The students were only given an introduction to the work of the PICU since they were not there for very long. The nurses would identify the types of equipment, demonstrate various procedures, and how those differed from the procedures carried out on adults. We would discuss the concept of primary nursing, as well as the children's psychological needs, and the importance of play and development of the child whilst resident on the PICU.
66. The students generally did not arrive with a set of objectives, but were there merely to observe the PICU. Their stay was not evaluated as they were on the PICU for such a short space of time. They were given a record of attendance. The students were supernumerary, meaning that they were not part of the nursing establishment and had no personal responsibility for patient care.
67. The PICU no longer takes students studying for the ENB 100 qualification. It was agreed with the University of the West of England that we should rationalise our intake of students to those who would obtain the most benefit. I am not sure when this decision was made. It may be that students studying for the ENB 100 qualification would never look after children at all. I cannot recall when PICU stopped receiving these students.

68. We continue to receive students undertaking the ENB 415 course (paediatric intensive care), as well as taking students on the RN Part 15 Children's Course and Project 2000 students.

69. Although I am no longer a mentor for those undertaking the ENB 100 course, I am still responsible for allocating students to mentors in the different teams.

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.

70. When I started on PICU, new nurses underwent a period of orientation of 4 weeks. They were supernumerary to the establishment. An experienced paediatric intensive care nurse "mentored" them. Without exception everyone who was appointed underwent this period of orientation. Now the supernumerary period is 6 weeks.

71. At BRHSC, if a new procedure is introduced in-house training sessions are conducted. Teaching is by experienced staff, medical and nursing, during work time, and the use of handouts and workbooks to complete.

K2: – K:27

72. I am unable to comment on the other issues in this section.

Issue L: Informed Consent


73. There were leaflets readily available in the PICU explaining the types of surgery that might be undertaken, including diagrams, for the parents. The surgeons would conduct ward rounds and speak to the parents before transfer to the BRI for surgery. If the parents wanted any further clarification, they were able to ask any of the nurses on the PICU. If the nurse was unable to answer the question, for example on the risks of the procedure, it was referred directly to the surgeon to answer.

Issue M: Review of Cases and Medical and Clinical Audit

74. I am unable to comment on this, as nurses were not involved in medical audit. More recently clinical audit has been developing, and that does involve non-medical staff.

Issue N: The Expression of Concerns

75. At the time I had no relevant experience to enable me to make any judgement or comparison of the paediatric cardiac surgical work in Bristol with standards elsewhere. I was aware that nursing colleagues in general, commented on how long surgery took at the BRI. At BRHSC we were quite separate from the BRI and I thought no more of it. I assumed at the time that this was complex, difficult surgery which could be expected to take a long time. Whilst a student on Ward 5, I was in no position to assess the surgery undertaken there because I was inexperienced and not there for very long.
76. In hindsight, I am aware that Mr Pawade's results are outstandingly good. I now know that the operation times used to be longer under Mr Wisheart and Mr Dhasmana, and I am aware that those who were involved felt that this was a significant factor in the outcomes. No one, to my knowledge, was critical of the surgeons' technical abilities – just their speed of operating. I am not in a position (then or now) to make such a judgement for myself. I also do not know whether it was felt that bypass times/lengths of operations were slow in all cases, or only for some procedures. I am not able to assist any further with this issue, as it did not really affect us at the BRHSC and I was very junior when I worked on Ward 5, BRI.

Signed.....

ALISA JANE HALL

Dated 18 Sept. 1999.....

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