

The BRI inquiry into paediatric cardiac surgery in Bristol (1984-1995)

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Background

1. I have previously provided a statement dated 4 October 1999, which covers Issues B and H. This statement covers aspects of issues C, D, E, F, G, I, J, K, L and M, to the extent that I am able to comment on these issues.
2. My previous statement gives a detailed summary of my employment history. I must stress that I only worked on the cardiac unit at the BRI for 6 months during the period covered by the inquiry (1984-1995) . This began from April 1990, when I took over the position of Nurse Manager for the cardiac unit, to cover for Julia Thomas' maternity leave, until later in 1990. After this time I had no contact with the cardiac unit. My comments and impressions are based on this short period.

Issue C: The Service Provided: Nature and Outcomes**Issue C1: The BRI data; the number and nature of the complex paediatric cardiac surgical procedures performed at the BRI from 1984-1995; and the outcomes achieved by such intervention**

3. I did not have access to such figures or data. The clinicians/surgeons had these figures, but at that time (1990) they were not routinely shown to nurses, and neither

did nurses expect to see them. The culture at the time was that clinical work was surgeon and/or doctor led.

Issue C2: The national context:

(a) the written data or information gathered or published, whether in the years 1984-1995 or subsequently, that would help to establish the range of outcomes obtained by, and/or to be expected of, similar units in the UK (and in particular, other institutions designated as supra-regional centres for neonatal and infant cardiac surgery), at the relevant times;

(b) the availability of such data or information, at the time (both nationally, and within the BRI)

4. As I did not have contact with any other cardiac units, I cannot make any comments on this issue.

Issues C3 – C7

5. As stated above, I was not privy to such information and therefore cannot comment.

Issue C8: Whether any factors suggest, or require the conclusion to be drawn, that the children presenting for cardiac surgery in Bristol were not representative of national trends or norms. Such factors might for instance, include:

(a) the age of the child at the date of referral for surgery;

(b) the clinical condition of the children presenting;

(c) the age of the child at the date of surgery;

(d) assessment of the merits or desirability of surgery in “high risk” cases

6. I have two comments to make on this issue. It was my impression that Mr James Wisheart operated on the more technically difficult cases. My perception was that

Mr James Wisheart was prepared to operate to give the child or baby a chance, where perhaps other surgeons might not have been prepared to operate at all. The other comment I can make is that the age group of the children was very wide and that a number of children were very ill by the time they arrived for surgery.

Issue C9: If so, the extent to which children presenting for surgery differed from such national trends or norms, and the reasons for these divergences

7. I did not have the information and cannot make any comment on this issue.

Issue D: Referrals

8. I had no direct involvement in the referral process. At one stage, I was asked to collect and provide information as to where (by postcode) patients came from, for the in-house IT team, "Infotech". I believe that this information was to be used for contracting purposes, as it was requested just before we obtained Trust status. This information, I assumed, enabled us to establish how many cases were being referred from each health authority. I was aware that a lot of children were referred from all over the southwest and from Wales.

Issue E: Pre-Operative Management of Cases**Issue E1: The arrangements and services available to manage the transfer of sick children from referring hospitals to the BRI****Issue E2: Where children were managed, pre-operatively, and under which clinical speciality**

9. Elective admissions usually came to the BRI a day or two beforehand for pre-operative tests, swabs etc., to ensure that they were fit for surgery. They were looked after pre-operatively in the nursery area of Ward 5. Some children were managed pre-operatively at the BRHSC, and then transferred to Ward 5, either to the nursery or via theatre. Those children who needed ventilation and had been in PICU at the BRHSC were the more ill children.
10. There was no retrieval service, at that time. Transfers were arranged by telephone, from doctor to doctor. Those that came from the BRHSC to theatre did so with the help of Avon Ambulance. Those who came direct, came under their own steam, or occasionally by hospital cars. If children were being transferred from another hospital in the region, they generally went to the BRHSC first. Occasionally an urgent case would be admitted direct to the BRI. I had no direct personal involvement in the making of any of these transfer arrangements.

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

11. The assessments at either the BRI or the BRHSC were by the paediatric cardiac surgeons and the paediatric cardiologists. They would want to make sure that the child was fit for surgery. Basic nursing observations were carried out from admission. The anaesthetists would also assess the child for fitness for a general anaesthetic pre-operatively.

Issue 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

12. I was not involved in any such decisions and cannot comment. These were decisions made by the medical staff.

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

13. I assume that the decision was between the paediatric cardiologist and the paediatric cardiac surgeons. As a nurse I was not involved in this process.

Issue E6: the organisation and management of theatre lists

14. The theatre sister, perfusionist and surgeons would determine the organisation and management of theatre lists. Following instructions from the cardiac surgeon, the relevant secretary, (i.e., Mr Wisheart or Mr Dhasmana's secretary) would contact the patient. Theatre lists were also reliant on the blood available and there would have had to be a balance of blood groups being operated on each day.

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

15. I cannot comment on this, which would be for the doctors to say.

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 the 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

16. We tried to avoid having to cancel or postpone cases because of the availability of nursing staff. There may have been one or two occasions when we had to cancel for this reason. I refer to paragraphs 23 and 25 of my previous statement. Wherever possible we also tried to ensure that the workload was balanced, so that we were not dealing with all the serious cases on one day, so that they were staggered with other less serious cases. The balance between adult and paediatric cases was arranged by the surgeons. Sometimes beds were "blocked" by emergencies.
17. We later set up a meeting where medical staff and nursing staff discussed relevant topics or issues. I refer to paragraph 14 of my first statement. These meetings enabled us to plan in a more organised fashion the operations that were to be carried out and the post-operative care.

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

18. I was not involved in referrals and cannot comment.

Issues E10 – E13:

19. I cannot comment on these issues.

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

20. Nurses routinely observed elective patients on admission and subsequently, to ensure basic fitness for surgery.

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

21. When the child was at the BRHSC parents were encouraged, wherever possible, to meet the staff on Ward 5. Both Helen Vegoda and Helen Stratton liaised with parents and, on their behalf, with ward staff at the 2 hospitals, in this situation. Once the parents and child were on Ward 5 the staff were very good at introducing themselves, and encouraging parents to help with their child's care, for example washing or turning the child, changing their nappies. Nurses worked up quite a good relationship with parents. As they were really looking after both the children and the families, this meant that both technically and emotionally, staff were giving 150% .

Issue F: Management of Surgery

Issues F1 – F6:

22. I cannot comment on these issues, as I did not manage the theatre team.

Paediatric nurses did not want to care for adults if they could work entirely with children in a unit dedicated to children. We could not always guarantee that a child would be on the unit.

26. The same number of staff were on ITU day and night. They provided constant one-to-one cover. Although, like all hospitals then, we had difficulty recruiting paediatric qualified nurses, we certainly had nurses with a great deal of experience of looking after children after cardiac surgery.

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

27. I cannot comment on this issue, save to say again that on Ward 5 we had nurses who were very experienced in caring for children after cardiac surgery.

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

28. There was liaison between the physiotherapists, medical staff etc. when reviewing the patient, to ensure there was a clear plan. There was also full liaison between staff of the same disciplines on hand-over between shifts.

Issue 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

29. I cannot comment on this issue.

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

30. There are clearly different requirements when treating adults and children, but essentially the difference is that looking after a child is far more emotive and, to a greater extent, involves looking after the whole family. Cardiac surgery is very stressful for every patient and every family, whether the patient is a child or an adult. This stress inevitably is shared with the nursing staff, who have to find ways to cope and still do their jobs effectively. When Helen Stratton was employed primarily to support parents, staff also had the opportunity to talk about any extra strain they were feeling.

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

31. The clinicians, surgeons or anaesthetists, chose the equipment. I would assess whether we had funds to pay for that piece of equipment. We were very lucky in that the unit had up to date equipment. We also had a lot of charitable donations which were put towards upgrading and updating equipment. Every day goods were ordered by the Sisters on the Ward.

Issue G10: The standards of 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)

32. In the BRI we were conscious that we cleared up every spillage straight after it occurred. We complied with the protocol set down for infection control. The BRI had one Infection Control nurse. She occasionally visited the unit. All ITU staff are very aware of the importance of strict infection control procedures when nursing very ill patients. If infections occurred, then the cardiac surgeon, anaesthetist, and microbiologist would get together and discuss the best way to treat the patient.

Issue G11: The management of discharge and future care

33. Whichever nurse was looking after the child would discuss discharge. I was not involved in discharge arrangements. The decision to discharge and arrangements for future care were the responsibility of the medical staff.

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

34. I refer to my comments under E15. The help that the parents could give was obviously restricted after an operation because a lot of the children were attached to various items of equipment. Generally, parents were encouraged to help as much as they felt able, or as was practical.

Issue I: Treatment of Families, including the Bereaved**Issues I1 - I5:**

35. Rev. Michael Jarvie was the full-time Anglican resident chaplain when I was in post. There was also one part-time Catholic and a Free Church Chaplain. I recall that Michael Jarvie used to pop in and out of the unit at least once a week. Staff would make parents aware that there was a Chaplain in the hospital if they needed one. If requested the Chaplain would be contacted. In 1990 the full-time Chaplain was covering numerous hospitals. It was felt that we needed one full-time member of staff designated solely to the cardiac unit who had time to liaise with parents. I spent a considerable amount of time with Jean Pratten (South West Heart Circle) in setting up this post and was included in the interview panel. The post was partly funded by the Southwest Heart Circle and partly by the hospital. We employed Helen Stratton in October 1990.
36. The role for Helen Vegoda (BRHSC) was not only to provide support, but also to arrange more practical issues such as transport, accommodation etc. The BRI post was not firmly enough established when I left, for there to be a close working liaison between both Helen Stratton and Helen Vegoda. Janice Shute, a staff nurse, was Helen Stratton's deputy and acted on her behalf when she was on holiday or sick. Social workers occasionally came to the unit to deal with matters such as benefits, financial problems, accommodation, etc.
37. A hostel run by the Southwest Heart Circle provided accommodation for some parents. Other parents stayed in bed and breakfast or local hotels. The Heart Circle also provided funds to renovate a room on Ward 5 where parents could wait during surgery or spend time with their baby if the child unfortunately died. There was a considerable distance between Ward 5 and the Chapel/Mortuary which led to this room being established on the ward.

38. All nursing staff showed great sensitivity even when they were quite often exhausted. Occasionally nursing staff also attended children's funerals, in order to further support the family.

Issue J: Post-Mortems and Inquests

Issues J1 – J4:

39. I was not involved in this and cannot comment.

Issue K: Training and Retraining**Issue 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**

40. All staff, where it was appropriate to the needs of the unit or themselves, would be encouraged to go on training courses. This clearly depended on what level they were at, and also on the results of their performance review. During those reviews we assessed the skills they wished to develop, or acquire, and provided appropriate training. The process for carrying out these performance reviews is described at paragraphs 10 and 11 of my first statement. The training could be internal; for example, if we had new pieces of equipment the sales representative would go through how to use it with us all. External training was also arranged. Sending staff on training affected staffing levels, so we could not let large numbers of staff go at one time. We adhered to a strict protocol as to how many could attend such courses and ensure adequate staffing levels were maintained on the ward. While staff were training, all remaining staff mucked in and did a little bit more than they would do normally.

Issues K2 – K27:

41. I cannot comment on any of these issues.

Issue L: Informed Consent**Issues L1 – L6:**

42. I did not attend pre-operative meetings with surgeons and families. I do not know what information was provided to parents. All the clinical notes included references to “risks and benefits explained”. Sometimes there were diagrams attached. I cannot remember whether there were any other details in the notes, for example the percentage risks involved. As I was not treating patients I did not discuss with parents what they had been told in the pre-operative meeting. The nurses who were caring for the children may have had such discussions with parents. I would have expected the nurse to call in the doctor again if parents remained unclear or unhappy about any aspect of the treatment or proposed treatment, and the nurse felt unable to explain or clarify it herself.

Issue M: Review of Cases and Medical and Clinical Audit**Issues M1 – M12:**

43. As I was in post on the cardiac unit for a very short period of time, I cannot comment. I knew that cardiac surgeons kept their own records of the operations they had performed, but that was the extent of my knowledge during that period.

SIGNED : Lorna Wilshire
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