

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

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Background

1. I have been asked to provide a first statement on issues B and H.
2. I qualified as a State Registered Nurse in 1968 at Hammersmith Hospital and stayed on at the hospital until April 1969, when I joined Queen Alexandra's Royal Army Nursing Corps. I stayed with the Army for 4 years and during this time I took my Part 1 midwifery exam. After leaving the Army I took 6 months off. In October 1970 I did the second part of my midwifery exams, in Southport. In October 1971 I moved to work at the Radcliffe Infirmary in Oxford. I spent some time as a sister on a Medical Ward and then transferred to ITU. I stayed in this hospital until January 1979 when I came to Bristol and commenced employment at the BRI.
3. From January 1979, I was the Nursing Officer for ITU, cardiac ward, x-ray and cardiology until April 1981, when I transferred on to night duty and became the Night Nursing Officer for the whole of the site. In April 1990 I took over the position of Nurse Manager for the Cardiac Unit, to cover for Julia Thomas' maternity leave, until later in 1990. When Julia returned I became an Assistant Manager in general surgery looking after the surgical outpatients department. In 1993 I became Associate General Manager for Dermatology and Genito-urinary Medicine and Rheumatology. In 1997 I took early retirement and was re-employed as a Manager for rheumatology for 2 days per week. I undertook a Return to Nurse

Practice course and returned to part-time nursing as a D grade nurse at the BRI in January 1998, working on trauma and orthopaedics.

Issue B: The BRI and its Paediatric Cardiac Surgery Unit**Issue B1: The structure of paediatric cardiac surgical services at the respective sites at the BRI and BRHSC, including:****(a) the services offered;**

4. Children who had open heart surgery at the BRI were nursed immediately post-operatively in the cardiac ITU area of ward 5. I was not aware of the detail of the remainder of the provision of these services.

(b) funding of services, and the incentives created thereby;

5. I have no information on this.

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

6. As a Nursing Officer, and later as Nurse Manager on the Cardiac Unit, I was responsible for the nursing staff on the relevant Unit.
7. As Nursing Officer, and later Nurse Manager for Cardiac, I was directly responsible to Debbie Evans, In-patient Services Manager for all management issues, and to Margaret Maisey, District Nurse Adviser and later the Trust Nursing Adviser, for professional nursing issues. I always knew that if there was a problem I could contact my immediate manager.
8. In respect of nursing staff, there were group meetings but I cannot now recall the frequency of these. They were probably every 6 weeks to 2 months. At Sisters' meetings we would discuss such things as recruitment, shifts, etc. My door was always open, and I would always try to get around to see staff on duty during the day.

9. There was a communications book kept in the coffee room on the Cardiac Unit, so that anybody could write in it any problems or information they wanted other people to know about. The types of information recorded into this book included, for example, the fact that staff were not now using a particular piece of equipment or item; that someone was going on holiday; requests for training sessions on a particular topic; and thank you cards and articles were placed in the book. It contained both general and professional information. I would pick up the communications book from time to time to read it, and then discuss any problems arising with the relevant staff. Alternatively, I, or someone else, may have written an answer to a question into the book. It was accessible to all members of staff. It was also useful because it meant that staff who were away for a period of time could pick up the book and find out what had been going on.
10. For purposes of staff development reviews, nursing staff were divided into teams with a mentor. These teams were set before I joined. The Sisters were usually the team leaders. Either a Sister or a Senior Staff Nurse would be the team's "mentor". This meant that all nurses at all levels knew who their mentors were, and who to contact if they had any problems or needed support. This was the best way of managing the number of staff on the unit, which as I recall was 70 plus. Teams did not have to meet on a regular basis. It was up to the teams themselves to determine how often they met formally.
11. The team leader carried out the development reviews for the members of their team. I carried out the Sisters' performance reviews as they became due.
12. Towards the end of my stay on the Cardiac Unit, regular formal meetings were set up and attended by the Consultants, Fiona Thomas, the Sisters and myself, in order to discuss the day-to-day running of the Unit.
13. During my stay on the Cardiac Unit the move of the paediatric cardiac service to the BRHSC was being planned and discussed.

(d) the extent to which medical and nursing staff were involved in management and managerial issues;

14. During my time on the Cardiac Unit we were trying to set up a meeting where clinicians could sit down with the nursing staff and discuss medical and other relevant topics or issues. This was necessary because of the likely change in management structure with Trust status. Mr Wisheart, Mr Dhasmana and Mr Hutter were supportive of this type of meeting. Towards the end of my time as Nurse Manager these meetings became regular. From memory, I think they were either weekly or fortnightly.

(e) facilities available at each site, including their use by other services, e.g. adult cardiac surgery;

15. As I recall there were 7 cardiac ITU beds. There was no set percentage split of beds between adults and children, although we tried not to have more than 2 children in the ITU at any one time because of the staffing implications. There was one high dependency bed adjacent to the ITU.

(f) 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);

16. Paediatric nurses are a specialist section of the nursing profession. They were always difficult to recruit. This was because they were never keen to look after adults, and could not be given a guarantee that there would always be children on ITU on Ward 5.

17. As Nurse Manager for the Cardiac Unit, part of my remit was to recruit for the whole cardiac unit, except for the theatre. Staff were rotated through the whole

ward in order that they could see the progression of their patients from admission to discharge.

18. At that time there were approximately 70 plus nursing staff on the Cardiac Unit, although I cannot remember the whole time equivalents. There was (and is) always quite a high turnover in ITU areas. As new staff were recruited others would leave. This was compounded by a 6 to 12 week period delay for recruitment as, in my recollection, I could not advertise for a replacement until the member of staff had actually left. Inevitably, because of the high number of staff, there were difficulties co-ordinating absences due to staff leaving, maternity leave, sickness and training needs. Absence always increases the pressure on the remaining staff and this was heightened by the pressure of working in an ITU environment.
19. I was responsible with Fiona Thomas for drafting job advertisements and Personnel would then take over. Once all the applications were received I would go through them with Fiona Thomas or one of the sisters and short list people for interview. Interviews would then be held by myself and Fiona Thomas, or by Fiona and one of the sisters. If it was a sister's post then, the interview panel would include a consultant and personnel manager (but not someone of equal grade).
20. Once employed, there was an induction programme for all staff. Staff then received additional training according to their experience. The less experienced would spend time working with someone more experienced. Fiona Thomas would make the decision as to the length of time that person would be trained. I left these detailed matters to Fiona Thomas.
21. For all staff there were teaching sessions carried out on a regular basis by the sisters, or medical staff, or outside sources. If staff wanted training on a particular matter, or if they wanted to spend time in another Unit, then if it was reasonable and appropriate, we would make arrangements for that to happen.

22. In relation to job descriptions I think they were in the process of being revised following clinical nurse grading.
23. Fiona Thomas was responsible for the off-duty rota on the Cardiac Unit. If there was a problem with this, for example because someone had gone off sick, we would possibly discuss it. We did use bank nurses, but it was often the case that it was easier to manage with what we had than to bring in someone who had no experience on the ward. It was rare to bring in an agency nurse, unless all else failed. We would try to look at who we had and see if we could shift people around. It was quite often the case that sisters dealt with the problems and only came to me if they could not resolve them.
24. Staff in the Unit wished to trial a 12-hour shift programme. I was not in favour of a 12 hour shift system as I had experienced this previously and it was very tiring, especially in an ITU area. Before I arrived the Unit had carried out their research and were very keen. They believed it would help continuity of care. There was also the attraction of more time off at the end of their shifts. I had reservations as I thought that nursing staff would be very tired and this would have a knock-on effect on sickness. The 12-hour shift system was trialed during my time on the Unit for 6 months. With the introduction of the 12-hour shifts the rota needed a lot more planning. Apparently, after the 6 months it was properly audited and the system was voted out. Sickness rates had indeed risen.
25. If all avenues failed, we had to close a bed. This did happen on occasion. It had to be approved at a higher level, and was only done as a last resort. Any problems would have been discussed with the surgeons, anaesthetists, senior managers and ward sisters to find the best solution.
26. In respect of shared appointments, I do not recall any formal job share arrangements although some staff did work part-time.

(g) regulatory and disciplinary structures;

27. The main area I can recall as being subject to disciplinary proceedings was drug errors. There were protocols for such errors. If someone made an error it had to be reported to medical staff and reported to management. The nurse/nurses in question would have to make a statement and I would then investigate the situation, and report to the appropriate senior manager. I cannot recall any drug or other errors whilst I was Nurse Manager. The same procedure would have taken place for any other error of professional judgment.
28. There were, of course, the professional regulations of the UKCC. There were other protocols set down by the BRI, for instance in respect of uniform, lifting, etc.

(h) counselling and support for staff;

29. There were numerous ways in which staff were supported and counselled. They were as follows:-
- (a) Helen Stratton was employed as a Counsellor/Cardiac Liaison Nurse. She could be contacted either formally or informally;
 - (b) staff could receive support from their team leader and/or mentor;
 - (c) there was a Hospital staff counsellor;
 - (d) staff supported each other. There was a very good social set up and they used to go out together a lot. Many of them had been on the Unit for a long time. Although it made it difficult for people coming from outside, I always felt that newcomers did not remain strangers for very long.

(i) relationship with the University of Bristol and other academic centres;

30. I cannot comment on this issue.

(j) key managers and clinicians: identities, powers and functions, collaboration between disciplines;

31. As I recall, the key anaesthetists were Dr Sally Masey, Dr Geoffrey Burton, Dr Chris Monk and Dr Steve Bolsin. The key surgeons were Mr James Wisheart, Mr Janardan Dhasmana and Mr Jonathan Hutter. In respect of managers, the key figures were Debbie Evans, Margaret Maisey and John Roylance.

(k) nature and scope of "outreach" clinics and other services offered by the paediatric cardiac team to local hospitals

32. I have no information to offer on this issue.

Issue B2: The implications and effect of designation, and de-designation, as a supra-regional centre upon the financing, organisation, management and delivery of paediatric cardiac services at Bristol

33. I have no information to offer on this issue.

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

34. The creation of the Trust was after my time in the Cardiac Unit. A lot of personnel were in shadow posts in the build up to Trust status. Everyone knew that the changes would be radical and were apprehensive of the change. We were all aware that there would be a Clinical Director and manager for each division, and that work would be governed by an internal market.

Issue B4: The implications of, and incentives created by, the means by which paediatric cardiac surgical services or staff members were financed or paid

35. I have no information to offer on this issue.

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

36. Staff were regularly appraised and any training needs were discussed. We were always trying to ensure that people's experience was growing. I do not recall any issues regarding the competence of nurses being raised.

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

37. I can provide no further information on this issue.

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

38. Staff were aware of the need to sign the patient's nursing Kardex, and to ensure that everything written was accurate, reliable, relevant and readable. I think I felt that the notes on our Unit were up-to-date and gave a good overall summary of what was happening with a particular patient. We also started at this time creating care plans, and these were being constantly evaluated.

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

39. On a day-to-day basis Fiona Thomas managed and co-ordinated the team but I oversaw it.

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

40. I was aware that the South West Heart Circle provided some information and advice to parents. I can add no further information on this issue.

Issue B10: Complaints procedures available to referring clinicians, and to members of the public, on the standards of treatment and care attained at the BRI

41. Written complaints would be made to senior managers who would then pass them to the person concerned for their comments. The senior manager would then write a response to the person who had complained. I cannot remember any written complaints during my time as Nurse Manager.

42. People could complain directly to me. If it was a simple practical thing, e.g., if there were no sandwiches in the machine, I could resolve it. If it was a staff issue, I would have had to take it further, but I do not recall any complaints of a professional nature whilst I was Nurse Manager for the Cardiac Unit.

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

43. I refer to my comments in B1(h). All the avenues of support I have set out were mechanisms available for staff to raise issues of concern. If a complaint had been made (which it was not during my time as Nurse Manager of the Cardiac Unit), then I would have gone to my Manager, Debbie Evans. I assume that she would have taken it higher if she had felt it was necessary.

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

44. At that time I felt that the unit was still very surgeon led. It was felt that the surgeons had the power, whilst nurses generally thought they were doing their bidding. The recent nurse grading exercise had caused a lowering of morale. At this time there were still a lot of appeals against the clinical nurse grading going through. When staff were unsuccessful in their appeal this lowered morale further. The team in the Cardiac Unit worked well together and were very loyal to each other, as were all the ward sisters. It was a very supportive atmosphere.
45. I cannot recall any complaints of poor service or care during my period. If there had been, I would have dealt with them in the best way possible, and as openly as possible.

Issue B13: The extent to which the structures and attitudes described under this Issue, B, differ from those commonly adopted by large organisations involved in risky activities; and the nature of any such differences

46. I can offer no information on this issue as I have not worked in another large hospital involving risky activities.

Issue H: The Split Site**Issue H1: The extent to which (if at all) the quality of care offered was adversely affected by the fact that paediatric cardiac surgery and immediate post-operative care were carried out within a cardiac theatre and ICU catering for both adults and children**

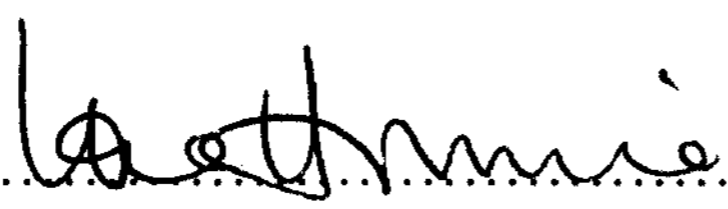
47. It was felt by most nursing staff that it was not appropriate for children to be nursed in an adult unit next to adults. The length of stay of the children in ITU sometimes caused delays to other operations. Delays also occurred in transferring patients back to BRHSC if a bed was not available in their ITU. (PICU).
48. One of the issues for nurses was also that a high percentage of children were transferred from BRHSC for surgery. The Unit staff had not had the chance to be involved in their care beforehand. In a sense the nurses were meeting the children “mid stream”, and often they were transferred back to the BRHSC after being on cardiac ITU. Continuity of care was inevitably interrupted, although staff tried to minimise this.
49. Parents were encouraged, when possible, to come down to the unit so that they could see what the ward was like and meet the staff who would be caring for their child. This of course was not always possible, especially with emergency transfers.
50. During my time as Nurse Manager on the Cardiac Unit, talks about moving the service up to the BRHSC were well into their planning stages. The proposed move was supported by a lot of people, but at that time we had to live and work with the split site scenario.

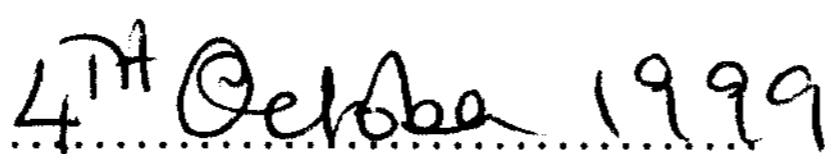
Issue H2: Communication and collaboration between the ICU of the BRI and the paediatric ICU of the Children's Hospital; and transfer of children between two sites

51. It was necessary to make sure that all notes were up to date prior to transfers. Nurses from the Unit would ring nurses at the BRHSC to discuss the case. The medical staff would go up to the BRHSC to visit the children post transfer and continue their care.

Issue H3: The response of the clinicians and the management of the BRI to any problems created by the split site

52. I was aware that clinicians were often concerned that the waiting lists for adults were being lengthened by the long stays of some children in cardiac ITU and by the number of emergency operations carried out

SIGNED : 
LORNA WILTSHIRE

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