Scottish Hospitals Inquiry

Witness Statement of

Gael Rolls

Witness Details

1. My name is Gael Rolls. I was previously employed by NHS Greater Glasgow and Clyde (NHSGGC). I now work with NHS England Specialised commissioning services in an Operational Delivery Network and am hosted by University Hospital Bristol and Weston.

2. My current role is Lead Nurse (LN) for the Surgery in Children Operational Delivery Network in the Southwest of England.

Professional Background

3. I graduated from the Western College of Nursing and Midwifery in 1989. I graduated as a Registered Children's Nurse on part 8 of the Nursing and Midwife Council (NMC) register. In circa 2003 I went on to achieve a distinction BSc in Specialist Practitioner Paediatric Intensive Care.

4. I graduated with a post graduate diploma in Advanced Nursing from Glasgow Caledonian University around 2008. I also completed the Scottish Improvement Leadership Skills course in 2020.

Awareness of Patients and Families Evidence

5. I am aware of some of the evidence given by patients and families, I have no further comment other than it is their experience and that is what they have spoken to.

Overview of Roles

Senior Charge Nurse - Paediatric Intensive Care Unit (PICU) – 2015 (in RHC) – April 2019

6. I was the designated Senior Charge Nurse (SCN) in Ward 1D (PICU). I was ward based and clinical and had a lot of administration to do within the role. I had clinical supervision of the nursing care being delivered o and. was responsible for the day-to-day running of the unit, to ensure that patients were being well cared for in an environment suitable for high quality healthcare to be delivered.

Acting Lead Nurse in PICU – February 2019 – April 2019

Acting Lead Nurse Inpatient Areas - April 2019 – June 2021

7. My role as LN was to ensure the safe running of all my areas of responsibility (from April 2019-June 2021 this included Wards 3A, 3B, 3C Renal, 3C Ortho, LTV service, Schiehallion day unit and Schiehallion inpatient ward including transplant patients. This included managing: Workforce (communication, retention and recruitment, absence management, training and education, adherence to NMC code, adherence to NHSGGC policies and including any HR issues), Environment (NHSGGC infection control policies observed, estates issues -feedback loop closed, domestic services oversight, area fit for purpose –caring for patients and parents). Patient safety (skill mix and staffing levels, observe quality indicators and action,) Leadership (role modelling, setting a good example, displaying professionalism, professional oversight). Communication was a key role. This ensured that there was a flow of communication from the senior leadership team to the ward staff. The chief nurse would also share professional advice which I would ensure was disseminated to all staff. I worked closely with Melanie Hutton, Clinical Services Manager, who was my line manager.

Managing Environment in RHC

8. If an estates issue arose, it could be raised by any member of staff. Every member of staff is vigilant at all times for anything that may need fixed. We would take advice from Estates and any other relevant professionals, as well as IC, who were always involved, in giving advice and in preparing an HAI scribe if required. Schiehallion used FM First, and also logged issues in a communication book, so that the ward had a written copy of any estates issues that had been raised. Both PICU and Schiehallion, used communication books, for estate's issues. This ensured a note of what the issue was, who requested it, when they requested it, and what the status of the repair was. Estates issues arose while Schiehallion was in Ward 6A and they were dealt with immediately according to policy with infection control involved throughout. An example would be a leak found in the kitchen and once the appliance was moved there was further concerns noted behind and underneath it. The estates department made sure that they worked under infection control guidance from an HAI scribe and investigated the issues that were found and rectified the problem.

9. There was a robust system of closing rooms in Ward 6A to ensure any estates works required could be carried out, following which the room would be decontaminated and handed back from the estates team to the ward nurse in charge.

10. Everything was carried out as per HAI scribe. The scribe is the process to ensure IC around any works being carried out. It's a step-by-step process of what must be done to ensure infection prevention and protection, there are actions which must be done by the estates worker, and description of what must be done post-remedial work to ensure the room is clean and fit for use. Once that's done, the room can be used again.

11. During the time period April 2019-June 2021 I was also responsible for Wards 3A (neurology, neurosurgery, endocrinology, long term ventilated patients, complex airway service) ,3B (gastroenterology, general surgery, specialist surgery), 3C Orthopaedic (ortho patients including chronic respiratory medical patients),3C Renal

and the long term ventilation service (children in community who receive LTV care from ventilation support workers)

12. Within RHC there are five lead nurses with different areas of responsibility. While I was in post there was a LN responsible for acute receiving including ED, Ward 2C, PICU,1E, Hospital @ Night, Resuscitation service, a LN responsible for Theatres, Day-surgery, pre-assessment, and out-patients and a LN responsible for clinical nurse specialists. There was another LN responsible for neonatal care in RHC, Royal Alexandra Hospital (RAH) and Princess Royal Maternity (PRM).

Patient Demographic

13. The patients in intensive care are critically ill children who may require support with their breathing, or circulation or require close observation and continuous monitoring in case of deterioration. This requires a higher ratio of nursing staff. Patients are usually cared for 1:1 in this area depending on their acuity.

Additional ward staff

14. In ward 3A there was also a LTV team to support the training and ongoing education needs of the ventilator support workers (VSW), as well as co-ordinate the VSW's to care for LTV patients in their own homes.

Schiehallion Ward

15. The Schiehallion Ward was on the second floor in RHC initially and then it moved to the adult hospital (QEUH) on the 6th floor and 4th floor, which was for transplant or severely immunocompromised patients. When I cared for Schiehallion patients, they were on the fourth and sixth floor of the adult hospital. When Schiehallion (Wards 2A and 2B) was in the Children's hospital it was on the second floor.

Intensive Care Ward

16. Ward 1D is the paediatric intensive care unit on the first floor of RHC. It consists of 22 beds. 4 4bedded cohort areas and 6 isolation rooms. There are two nursing hubs at either end of the unit, both of which have central patient monitoring.

Ward 4B and Ward 6A

17. The fact there were no facilities for the parents within the adult hospital Wards was very difficult for the families. They were reliant upon the Schiehallion staff to bring them snacks and refreshments from a trolley, which the staff in Ward 6A did frequently. The staff were very aware of how necessary it was for parents and children to have access to drinks and snacks. Parents did not want to always have leave their children and go to the retail or canteen areas in the hospital. Partly to avoid mixing with a large group of people as they were trying to minimise exposure from others to their child, and because they wanted to stay near their child and not leave the area completely. The nurses were obviously mindful of IC so would make sure everything was single use, everything was wrapped individually and was decontaminated between rooms. This snack service was for patients as well as parents and visitors.

18. In an environment where families are for such a long period of time, it was very much needed. The staff would ask families what could be done to improve their everyday life whilst their child was in the ward. The frequent response was 'we would love a parent's room'. It was expected initially for the move to Ward 6A/4B to be a short term decant but then it became clear that it was going to be longer. A parent's room was something that was required as an interim measure on Ward 6A and was requested by staff and parents on the ward to NHSGGC board members and the RHC senior leadership team during ward visits. The room was achieved fairly quickly but I can't give a timeline of when the parents' room did open on ward 6A as I can't remember.

CHRONOLOGY OF EVENTS

PRE 2015 – PLANNING STAGE

19. In 2015 I was working in intensive care. I was part of the design team for that area and had contributed to plans on what the environment would need to achieve when we moved and how we would work as a team within that space. At the time, I was the designated SCN in PICU which became Ward 1D after the move.

20. There was a team of PICU doctors, nurses and allied health professionals involved with the planning design and I was asked for an opinion on the areas that I had an understanding of. I did not give any input to the built environment. My input was based around how we could best organise the space to meet the nursing and clinical needs of critically ill patients.

21. Before moving to the new hospital, we were aware of what the new PICU was like. We had the opportunity to visit the new hospital on several occasions to orientate staff to the new environment. All staff within PICU were offered the opportunity to visit prior to the hospital move date. There was also planning to ensure that equipment needing replaced was achieved prior to moving, so we were able to move with a lot of new equipment including patient monitors, bedside computers and keyboards, patient beds, visitor chairs etc.

22. Not all of our suggestions or requests for the new unit were included in the final plans. I can't remember all of them, but one would be the example I give later when discussing HEPA filtration within our PPVL rooms. I don't know why this was not included in the final build.

23. For the last year prior to move, my colleague was heavily involved. She was the other SCN in PICU and along with one of the PICU consultants made our eventual move very smooth as all critical care needs had been planned. I was responsible for

planning staffing of the week of the move to ensure we had a complement of skilled nursing staff covering both Yorkhill and RHC while we had ICU patients and while ED and the wards had any remaining patients.

General views on the opening of RHC and comparisons with Yorkhill Hospital

24. When we first moved to the new hospital in 2015, I thought it was a good hospital. I can't comment on the internal built environment because that was something I had no awareness of until latterly. The curve of the wall within the wards were a challenge due to visibility of patients that wasn't present within Yorkhill. I don't have any comment as to whether it should be called a state-of-the-art facility.

25. The biggest difference from Yorkhill PICU, is that in Yorkhill the clinical environment was more open. There was still 6 isolation rooms but the remaining bedspaces were visible from the nurses station.Another change was that there was less clinical bedspaces in RHC, which has a fixed complement of 22 beds. In Yorkhill there was more space as there was another clinical area which mostly cared for highly dependent patients but had a further 4 bedspaces and 2 isolation rooms.

Common Issues (Exterior of the building)

26. On one occasion the staff were informed that scaffolding was going to be erected to deal with an issue on the outside of the building. I can't be more specific and I think this was back in 2016. I am not aware of any families within intensive care raising any concerns. I don't recall how we were informed about the issues with the cladding.

27. I have now been provided with a Core Brief that I vaguely remember seeing after Grenfell, **(A38845623 – Core Brief dated 12 July 2017 – Bundle 5 – Page 67)**. There were some windows that fell out in the hospital, but I don't remember all the

details. I remember this happening, but I wasn't concerned because when it was communicated to the staff, we were told what was put in place to ensure safety.

28. I am not aware of any those building issues while I was in PICU affecting any of the patients and families.

Common Issues (Interior of the building)

29. We never had HEPA filtration in Yorkhill Hospital PICU, but we had considered that it might be a good addition to our new build. We requested it be included in a couple of PPVL rooms in PICU at planning stages although it wasn't initially fitted when we moved into the new build. I know that it was retrofitted, but I can't remember dates.

30. I have been provided with minutes from an IMT **(A37987226 – Incident Management Meeting, dated 5 August 2016, relating to Increase in Aspergillus Infections in Schiehallion Unit – Bundle 1 – Page 22)** which was related to the increase in aspergillus cases in the Schiehallion Unit. I wasn't present at this meeting but note that I have been mentioned in the minutes. This is the first time I have seen these minutes and was not aware that I had been mentioned prior to this. I don't know if I was asked about HEPA filtration within PICU as an action of this meeting.

31. Within intensive care I am not aware of any Wi-Fi issues. We had the odd time a DECT phone call would drop out, but that would be fixed by Estates. As soon as we came across any areas of concern around IT coverage, we escalated that to Estates and IT, and I'm sure there were extra Wi-Fi points put in in the ceilings to ensure continuous service without dropouts.

32. I have been provided with minutes from an IMT in June 2018, **(A37989601 – Incident Management Meeting Minute, dated 6 June 2018 relating to increase in Acinetobacter within PICU – Bundle 1 – Page 105)**. I am mentioned in these

minutes, but I wasn't present. This increase was in PICU and I wouldn't know if there was an increase elsewhere in the hospital. There was a previous cluster in PICU and all I can really remember is that the number of cases never breached the control line on the SPC chart held by IC.

33. Quite often by the time we had the IMT, we would only maybe have one or two patients in the unit because it takes time for the samples taken to grow a result, and then there would be an IMT immediately following that. Some of the infected patients would have improved during this time period and been discharged from PICU.

34. Further in these minutes it mentions that I provided Pat Coyne with a list of beds that needed twice daily cleans. This refers to isolation rooms not actual beds, it's referring to patients in isolation rooms and the rooms required a second daily clean as per infection control policy. Twice daily cleaning is an infection control measure. If the second cleaning didn't take place this would be escalated until the cleaning, took place.

35. The minutes mention Dr Spenceley raising concerns about staff shortages. This is not something I can make any comment on as I do not know specifically what his concerns were around staffing whether he was referring to the workforce strategically or in relation to any occasion. To my memory he did not mention any specific date or time, and this is not my recollection. I would always ensure there was enough staff to care for the patients on any given shift. There were procedures in place that ensured there was always support to ensure safe staffing levels in PICU and these staff would have the appropriate training to work with the patients which they were allocated with supervision from experienced PICU staff. . RHC have twice daily safety huddles where amongst other things patient activity and acuity is described for each clinical area and any staffing requirements would be considered and a plan put in place to ensure patient safety.

36. I have been provided with minutes from an IMT to discuss the rise of Acinetobacter in PICU, **(A37990970 – Incident Management Meeting Minute, dated 3 July 2918 relating to increase in Acinetobacter within PICU – Bundle 1 – Page 140)**. At the time of the meeting there were four cases of inpatients within PICU with positive test results of Acinetobacter

37. The minutes from the meeting talk about a sample from a blind BAL. This means it's a sample of fluid from deep within the patient's lung. If the patient has any respiratory infections they would get picked up by this procedure. As an action following an IMT or PAG regarding Acinetobacter in PICU, blind BAL practice was investigated by one of the PICU consultants and a member of infection control and new guidance was issued around the process of sampling of blind BAL, this was to eliminate any possibility of contamination of samples. I don't know if this was arising from this meeting or another. Another action arising was further education to the PICU nursing staff from the complex airway clinical nurse around tracheostomy site and tube care.

38. Achtichlor is a chlorine-based agent used in decontamination according to IC policies. This has different strengths for different uses. Enzymatic cleaning powder is used for cleaning tracheostomy tubes to be reused for a single patient.

39. At this meeting I enquired whether specialist ventilators called High frequency oscillators could be swabbed. The reason these would be swabbed is as part of an elimination process. Everything else around the patient had been swabbed so these were be included in the surveillance of the environment. I remember making the request for this but I can't remember anything else. I don't remember any changes around use of the oscillator following that, so I can only presume that the results did not show any area of concern.

40. I also took an action from this meeting to ensure current patients in PICU would be screened for Acinetobacter. This would have been a request from microbiology or IC

team, just to ensure there was no more patients infected in PICU than this cluster we had already seen. I don't think there were any more Acinetobacter cases identified from surveillance at that time.

41. I have been provided with minutes from next IMT that I attended, **(A37991121 – Incident Management Meeting Minutes, dated 6 July 2018 relating to increase in Acinetobacter within PICU – Bundle 1 – Page 145)**. I have no recollection of this meeting. The meeting was again to discuss the increased cases of Acinetobacter within PICU. The minute states that I was to remind staff about ensuring all trolleys were to be emptied after being in an isolation room where a patient has Transmission-based Precaution (TBPs) in place. I would have ensured any action/s assigned to me was done.

42. Any non disposable equipment would be cleaned according to infection control decontamination procedures of near patient equipment.

43. The minute states that I asked for the ventilation covers in the ceilings pre-planned maintenance cleaning schedule for the PICU. I know the cleaning was being carried out I just wanted prior knowledge as to when this cleaning would take place. This would also allow me to know when the next cleaning was due and ensure that there were no issues with access as much as clinically possible.

44. If patients developed HAI infections such as Acinetobacter, part of infection control and my actions would be to ensure compliance with hand hygiene by reviewing recent audit scores and identifying any areas of concern for action. In PICU there was on-going education sessions to ensure everyone knew what was expected of them. Hand hygiene is everyone's responsibility and staff were regularly reminded to challenge any areas of non compliance that was seen and to inform the SCN who would have a further action to ensure the staff member was not requiring education or any other support to maintain HH. The most common cause for failing hand hygiene audits was the amount of time taken while washing hands. Signage was put at every hand wash sink within the unit with lyrics from a song which helped staff to

ensure the correct amount of time was being taken. NHSGGC's hand hygiene co-ordinator regularly carried out audits and bedside education within PICU. He would use different opportunities targeting various groups of staff. For example, he would occasionally join the ward round and promote good hand hygiene amongst visiting and PICU multidisciplinary team members.

45. Under risk management in the minutes it states a lot of patient movement within PICU was noted. Within PICU patient dependency is a factor in the decision to move bed spaces. This allows 2 patients who are less critically ill and not requiring 1:1 ratios of nursing care to be cared for by one nurse.

46. If a patient doesn't need to be in an isolation room, they would get removed from isolation policy measures. Quite often people will go into an isolation room prior to results coming back, especially if admitted with a respiratory illness.

The Water Supply

47. I had no concerns around the water system in RHC in 2015 and 2016 and had no concerns until the issues were communicated to the clinical teams along with the safety measures being put in place such as chlorine dosing and the application of water filters onto taps. Within PICU we were monitoring ventilator associated pneumonia (VAP) and central line associated blood stream infection (CLABSI) rates and had not noticed any increase which may have prompted concern. The Acinetobacter positive patients were mostly receiving those results from blind BAL which was being done as a routine test. Since moving to RHC the clinicians had started to increase the amount of blind BAL tests that they were performing on patients and it became a routine test. This was not a procedure that was carried out routinely in Yorkhill.

48. One of the parents in 3A had mentioned concerns about the water around December 2019. The mother certainly had concerns regarding water because there

were filters on the taps. Parents in the surgical wards and Ward 6A/4B did occasionally raise concerns with nursing staff and myself regarding the water supply and we reassured them with the information we had at the time regarding what measures were in place to ensure water was safe for use. The mum spoke to one of the nursing staff in ward 3A to raise concerns. She was handed a jug of water for drinking and she refused to offer that to her son or to drink it herself. She stated that they would drink bottled water instead and would bring their own water in from home. The mother also did not want to wash her child in our facilities because of the water. I went to speak to the Mum just to reassure her that the water had been tested and that we knew it was potable and it was safe to drink and safe to use for washing. She went on to discuss this issue with the CN too as she was not satisfied with my responses to her. The mum was encouraged to use the shower facilities in her child's room as it was best for infection prevention and protection for her child to be kept clean.

49. At that point in time, we were saying that people could drink the water. We were advising people to have jugs of water. We were also giving them out in Schiehallion at that time. We were saying the water was safe to drink. There were no concerns from our point of view and that was communicated to all staff from the SMT.

50. There was a period of time where we were given bottled water. I can't remember what the instructions were round that, or if that was to do with the fact the water coolers had been removed. Once the filters were put on, I was concerned what the situation had been prior to that. After the filters were on, we were told the water was being tested regularly and was safe.

51. With communication around the water supply issues, I was not involved in press releases. I would always pay attention to them, and I'd be aware of them because they would give the staff information I can't remember how different the press release would be compared to the information given to patients and families.

Communication regarding the water supply while LN for Schiehallion

52. Information would be communicated from the CN to me and I would then go and speak to the staff on duty with the SCN and we would leave written communication in their nursing handover on a shared drive which was on every computer within the ward. The staff would subsequently speak to parents and families that were in the ward. Where the was certain communication from the senior management team and/or the healthboard/ScotGov, then the Chief Nurse and I would go to Ward 6A/Daycare and Ward 4B and we would give the written communication to them as well as verbally discuss what was written and ask if they had any further questions. This was documented in the child's case notes. Who communication originated from depended on the situation.

53. I would always pay attention to any press releases regarding the water within RHC, that Staff and parents and patients were given information and updates regarding the situation, this could be communication from various sources and we would follow the process above to ensure all parents/carers and where appropriate patients as well as staff were kept fully informed. There may be a press release regarding this updated information, but sometimes this was only released to the press if it was requested.

54. Communication on the ward also happened on an ad hoc basis between parents and nurses providing patient care. The SCN's were always available to speak with parents if they wished or if a parent wished to escalate any concerns. Similarly, I was available as was the CN if parents wished to speak to someone else and escalate any concerns they may have regarding any aspect of their child's care.

55. When patients were admitted to the ward, they would be informed of the ward routine and also of the routine water testing and filter changes that happened. In Ward 6A parents would also be informed of the need to move rooms for chilled

beam cleaning and that there would be routine inspection of their environment to ensure standards of infection control were being met.

56. I don't think that there was delay in receiving communication from the IMT's to give to patients and families. Sometimes you would maybe hear a plan at the IMT, but it needed to be evidence-based, and fact-checked before it would be communicated further. Sometimes there were communications which I think would go through Scottish Government for sign-off. We were never told what we could and couldn't say to patients and families. If we knew anything, then we shared it with staff and parents/carers alike.

INFECTIONS – Acinetobacter in PICU

57. There's a process for doing hand hygiene. There are moments of opportunity and technique and all these are assessed. One of the things to consider when an infection is seen is to consider what the hand hygiene audits results have been. The nursing staff caring for the patients would routinely remind parents/carers, visitors, visiting staff etc. to wash their hands and the process to do that before approaching a patient. There are monthly hand hygiene audits carried out in all wards and departments. That's done by Local Hand Hygiene Coordinators, and you will pick staff, and train them. NHSGGC has a training module, and you'll train staff to be able to do hand hygiene audits, and they will do them discreetly throughout the month. The hand hygiene co-ordinator carried out monthly audits up in Ward 6A for a period of time. He would also take the opportunity to carry out education of staff while on any ward. Any Areas of non-compliance would be targeted. It would be highlighted, and all staff made aware of it.

58. Acinetobacter became a concern in Ward 1D PICU in RHC as it was a recurring infection in the unit. The staff, nursing and medical in PICU work closely with microbiology staff and infection control staff on a routine day to day basis anyway and whenever a positive result was obtained for Acinetobacter all teams above were

aware. Microbiology would process the results and highlight their concern to both PICU nurses and clinicians at the same time as informing IC team, so we all became aware as soon as possible. IC would decide when to call a problem assessment group meeting (PAG) and we would have representation from all stakeholders at that meeting including consultant clinicians, senior nursing, IC doctor and nurse, microbiologist, and a senior member of the estates and general services team. At this meeting it would be decided how to proceed with further investigation or actions and decision may be pending whether it would proceed to an incident management team (IMT) meeting. IC chaired the meeting and would perform HIATT scoring at the end.

59. Domestic services would request a deep clean of the clinical areas and would perform a further audit of the unit to ensure cleanliness was being routinely maintained by the current schedule of cleaning.

60. Following identification of patients infected with Acinetobacter, the parents of the child were informed with full duty of candour and this was usually done by the consultant intensivist who explained what it would mean for the child in their current condition and answer any questions which arose. This would be reinforced by the bedside nurse who would be present during the parent conversation and who could also go on to answer further questions if they arose.

61. The Oversight Board records show Acinetobacter popping up in 2016, 2017, 2018 and 2019. I don’t remember a time and date. I just remember there were instances. I do remember it was a trigger for me to be concerned, because it was a recurring infection. We measured our ventilator associated (respiratory) and blood stream infections monthly. Following the move to RHC, in critical care it had been possible to reduce our VAP rates by 70-80%. This was an achievement which won an award from the Scottish Patient Safety Programme. This improvement was likely due to several factors including new profiling cots which were delivered around the time of the move to the new hospital.

62. IC swabbed everything in the environment and we swabbed all our ventilators looking for a source of Acinetobacter but we never found it. The cases of Acinetobacter within PICU were resolved either by patient discharge or by the patient testing negative for the organism.

63. There is duty of candour, which we would always carry out. We wouldn't have any delay. if it was thought that there was infection related to the clinical environment then that would be shared with the parent but we would always ensure the child's consultant had a conversation around the infection with the parents as they are best placed to address any further queries a parent/carer may have with regards to the effects on their child in the current time and in the future.

64. The impact on patients from getting an infection can depend. It can range from nothing, and patients can be colonised with an organism which, isn't making them unwell, or patients can suffer harm and have illness, minor or severe which may require further intensive care treatment to support their organs. It can prolong the length of stay you are in intensive care or in hospital, it can mean patients require antibiotics, it can possibly mean the patients needs to have a central venous access device removed or cannot have one inserted until the infection is clear and it can cause other treatment such as chemotherapy to be delayed or omitted which may have consequence on any underlying oncology progress, or it can cause death.

<u>Closure of Wards 2A and 2B and Movement to Ward 6A</u>

65. The involvement I had in the movement from RHC to QEUH for wards 2A/B was the emergency response from PICU to Ward 6A/4Bin case of clinical deterioration. We signposted our journey from PICU towards Ward 6A/4B because it wasn't a familiar route to go for a child resuscitation, so we made sure that all our teams within PICU were aware of the change. We made sure that everybody knew how to get to the wards and knew the best way; we had access from lifts on the adult side so we

could get everybody there as quickly as they needed to be, we did test runs where it was planned and timed, the route was mapped, and signposted.

66. I don't know why Ward 6A and 4B were picked. I imagine 4B was chosen because that environment was already being used for adult patients receiving BMT, so it was deemed a safe environment for paediatric patients receiving BMT.

67. Ward 6A was built as an adult ward then changed into use for paediatric oncology patients. As time went on, we found some issues with the environment such as lack of parent facilities and lack of patient playrooms that needed action and we found some IC issues arose that needed dealt with., The issues were dealt with as they arose and rectifications taken. Both the playroom and the parents rooms were commissioned following visits from the health board and SMT to Ward 6A where staff highlighted the difficulties caring for patients and families in that environment. Estates issues were managed as they arose with prompt action from that team.

68. I am aware of the use of source isolation but this was only ever used when totally necessary because of a child's clinical condition. I am not aware of any excess use of this. Source isolation is only used when deemed necessary by the IC policies.

69. If Ward 6A was full and a patient needed to be admitted through urgent care, they could sometimes go into another ward, into an appropriate room. There is a pathway which describes the rooms which are appropriate to accept Schiehallion patients, and that is kept by the Bed Manager, the Duty Manager and every SCN in every area in the hospital. None of these moves would affect the care the patients received; the care would remain the same.

70. The PPVL room has a ventilated lobby It is a room with double doors and airflow is positive meaning the air in the room is being pushed out towards the corridor. Some Outside the PPVL rooms are monitors which let the ward staff know what the air pressure is inside the room. These are monitored daily and have parameters to be

maintained. It is necessary to contact estates department if the readings fall out with designated parameters.

<u>Events in late 2018/2019 whilst the Schiehalion Unit was on wards 6A/4B</u>

71. There was an incidence of Cryptococcus in a patient while I was working [redacted]. I had no involvement in any discussions around that or any care of [redacted].

72. There was a leak from the ceiling at one point within Ward 6A. The estates department were notified and they attended the incident and switched a valve off to stop the leak. It was later reported that a valve had lost integrity on a hot water pipe. IC were notified.

73. The position of the day care to the ward was not optimal because patients had to come in through a ward entrance and walk up a communal walkway in the ward, before they could get to day care. In an ideal world, that would have been the opposite way around and we would have the ward at the other end so people accessing day care didn't have to walk all the way through the ward.

74. I was in ward 6A when the ward was closed to new admissions in autumn 2019. There was a cluster of gram-negative infections at that point but I don't think they were all the same organism. I can't remember clearly, but I think there was similarities and there were concerns that they were attributable to either the water or the environment within 6A. At that point the decision from the IMT was not to admit new patients until they were quite sure that the environment within 6A wasn't contributing to these infections. I couldn't tell you how long the ward was closed to new admissions.

75. There was concern at some point around the chilled beam system dripping water occasionally. The Estates department investigated each occasion when it was reported. There was chilled beam cleaning which was a process that occurred every

six weeks and each chilled beam system was cleaned. It meant that the patients were moved rooms in the ward quite a lot as the room required to be empty during cleaning for IC purposes.

76. Parents were aware of the routine of chilled beam cleaning necessitating a room move every 6 weeks. Any moves required for ad-hoc estates rectifications were discussed with them at the time the defects were found. An example would be when the toilet flush would fail, which happened frequently at one point within Ward 6A and the patient and parent would be moved to another room while the defect was repaired. IC scribe procedures would be followed for decontamination of the room before estates would hand it back to the ward for another patient use. Families were told what the defect was and when it would be repaired and that they were being moved rooms for infection control and prevention purposes.

Late 2019 to March 2022 (the move back to 2A/2B)

77. Ward 6A/4B staff continued central line surveillance, and achieved good rates, displaying minimal line associated blood stream infections. I left GG+C before ward 2A and 2B reopened in RHC last year.

Ventilation System Issues

78. I am aware that the environment within the hospital was a sealed environment, so we were reliant on the airflows and the air cooling and heating system within the hospital. I had an awareness of the condition of the air vents and would ensure access for planned maintenance and cleaning. If any vent required cleaning out with the schedule, estates would respond to the request for cleaning.

79. There was a very good working relationship with the estates department and we had a designated contact who was responsible for our areas that we could make requests to directly even although they were also reported onto FMfirst. This was

encouraged and helped to ensure a swift response. I also had contacts of more senior estates department who I could escalate concerns to and expedite a response if it was necessary.

80. This close type of working relationship very much echoed that which the SCN and I had with the general services team who would regularly visit the ward, audit environment and meals experiences, I was in contact with the senior members of the team regularly to discuss the ward with a view to making improvements where possible. An example would be in relation to the food served to patients in Ward 6A/4B and as a response the team introduced a new catering initiative to allow patients more choice of 'deli style' foods rather than meals, which also remained an option. The IC team members were well known throughout the hospital and worked closely with the clinical teams at all points. As before we had allocated members of staff who worked within the paediatric environment and that the ward teams were in regular contact with. As before with the other teams, there was access to escalate any issue with a more senior member of the team who had thorough understanding of the ward and patients.

OTHER INFECTIONS IN PICU

81. I wasn't aware of any other infections in PICU that were recurring in clusters like Acinetobacter.

82. I can't remember clearly but in January/February 2019 there was five gram-negative bacteria of two pseudomonas, two Acinetobacter and one Serratia which led to a PAG.I think there had possibly been some Serratia infections prior to that who were patients that had previously had serratia when they were inpatients in Neonatal ICU (NICU). Pseudomonas is a water borne infection and IC swabbed sinks within PICU. The IC team also would have done an environmental audit of the unit, looking to ensure water-based precautions were in place. An example would be ensuring water from ventilator circuits was disposed of correctly and that nothing other than hand

washing water ever was disposed down a sink drain. In regard to patients and family's communication, I can't remember this specific case but I expect they were made aware of the infections and that they were environmental organisms. The usual process would be to tell parents everything we knew in regards to what the infection was, how it was likely to have been contracted and what the implications were for their child at that time and any potential future implications.

Infections in Schiehallion

83. I have been provided with minutes from an IMT meeting, **(A36591625 – Incident Management Meeting Minute, dated 19 June 2019 relating to Ward 6A Gram Negative Blood (1) – Bundle 1 – Page 320)**. This meeting was called after a PAG meeting had taken place to discuss 4 cases of Gram negative bacteria (GNB). GNB may result in sepsis or line complications. Because of that the child might have to have their line removed. They could become seriously unwell and it could cause a delay to treatment or they may clinically deteriorate and even require intensive care. Antibiotics would be needed.

84. Two patients in ward 6A were discovered to have Mycobacteria Chelonae. They are the only two patients I have ever heard having that bacteria, I had never been aware of it before. I have no knowledge of anything further regarding those patients and their Chelonae diagnosis.

85. There is part of this IMT which says, "Parents not to be informed of gram-negative bacteria at present as no inconclusive evidence it's due to healthcare environment". My understanding is that staff shouldn't say it was a healthcare environment associated gram-negative bacteria because at the time we didn't know if it was healthcare environment associated or not. At that time, we didn't have the evidence to link the infection with environment so we didn't tell them that at that time.

86. I was happy with the information the families were receiving. Patients who had infections knew that they did, what the infections were and what the course of treatment was for. The SMT made decisions about what to communicate to patients and families, taking the ICD's advice at that time.

87. I am aware some Schiehallion patients had infections that were attributed to the environment, but I can't say how many. I gained this understanding from the IMTs. That would have been decided then, what was attributed to environment and what wasn't.

88. There was another IMT to discuss infections in Ward 6A and I have been provided with the minutes to this **(A36591622 – Incident Management Meeting Minute, dated 25 June 2019 relating to Ward 6A Gram Negative Blood (2) – Bundle 1 – Page 325)**. The IMT was called to discuss the 6 GNB positive cases in ward 6A, which had occurred in the last 3 months. Out of the six, 2 are Healthcare Acquired Infections and the 4 are Healthcare Associated Infections. When trying to source the cause of infection, if it is a healthcare acquired infection, the IC team investigates ward compliance with infection control procedures such as transmission based precautions including hand hygiene, and compliance with central line bundle maintenance, pvc bundles, and Aseptic non-touch technique (ANTT) for administering IV medications as well as observing the ward environment including recent domestic and estates scores

89. ANTT is a method used for administering medication to a patient. The aseptic non-touch technique is a whole programme of techniques. It requires education and training in the process before being deemed proficient. Schiehallion used educators from other areas, in the hospital to evaluate staff on ANTT technique, to ensure that they were still compliant with all the elements within the programme as part of quality assurance.

90. Initially The filters were put on places which were felt to be a part of the high risk patient pathway. They didn't go onto every outlet in every ward, and at that point they were not included in theatres. They were later added to theatres and drain cleaning was done in that area.

91. IC carry out IPCAT audits looking at the clinical environment. Every single ward has this assurance process from IC. It looks at your transmission-based precautions, your standard control of infection procedures IC practice in the ward is inspected and part of it includes whether you were displaying results of your audits.

92. The results from IPCAT audits are entered onto an electronic format. The SCN's would be told that the results were available. They would receive an alert from the system that it's entered onto, letting them know that this was there. We would always be told as well, so we could review the results and actions required, if any. Actions required to be completed within a set timescale based on the criticality of the rectification. As well as ICT led IPCAT audits, which occur across the health board, within Schiehallion weekly audits called enhanced supervision was carried out. Enhanced supervision within Ward 6A consisted of a member of the Estates team, myself as Schiehallion's LN, the Infection Control Nurse (ICN the nurse in charge of the ward, Ward SCN, and a member of the general services team. The team would randomly pick rooms to look at as long as clinically appropriate. They would look at a number of occupied clinical rooms, and if possible, a number of unoccupied clinical rooms, as well as a number of the day care unit rooms, and the disposal room containing the sluice, and the clean prep area.

93. Anything required as a rectification was noted, and notes given to the nurse in charge, senior management team as well as the estates and IC teams, with a closed feedback loop with a date of when the rectification was completed.

94. I was further mentioned in the minutes about working out a schedule of cleaning for certain theatres. I believe that refers to when I contacted the Theatres Lead Nurse to

ask that he facilitated access for the drain cleaning of Theatres. The minutes go onto mention shock dosing for water tanks. I am aware this happened but don't know further details.

95. I did attend another IMT regarding the Gram Negative infections in Ward 6A. I have been provided with the minutes for these **(A36591628 – Incident Management Meeting Minutes, dated 3 July 2019 relating to Ward 6A Gram Negative Blood (3) – Bundle 1 – Page 330)**. This was called to again discuss the 6 GNB in ward 6A. Water results were discussed, one of which related to being traced in an ARJO bath Estates were requested, on the basis that the bath was a little used water outlet, to remove this bath in ward 6A as it was not used.

Infection Monitoring, Reporting and Infection Prevention Control

Infection Prevention Control (IPC)

96. Part of my role, and every other nurse, is IC. It's part of the SCN's role as well to ensure they're monitoring this all the time. There was a very close relationship with the IC team and the ward. There was always communication around IC with the staff whether when on enhanced supervision or as part of daily ward visiting. The IC team were often in the ward observing care given and reviewing care plans and they also discussed IC with the staff on shift regularly. My understanding of a Hospital Acquired Infection is that it is an infection which develops in a patient within a certain amount of time that they have been in contact with the hospital. They may have been an in-patient or out-patient and receiving treatment, so having their line accessed within hospital.

97. A healthcare associated infection is something where the patient's perhaps not been in hospital during a certain period of time, which IC will tell you what that time is. We would expect IC to give us that definition, they would be the ones who would have the information to do the root cause analysis (RCA) and look at other things and decide whether it's a healthcare associated or a healthcare acquired infection.

98. Any infection is highlighted by the clinical team, microbiologist and IC team. The more integrity of your skin is breached, the more at risk you are of developing an infection. Obviously the less immune system you have for whatever reason, either hereditary, treatment or disease, then you're more likely to be susceptible to infection. In ward 4B, where the patients are receiving BMT and they've got no immunity prior to receiving transplant, these patients are our most vulnerable patients, which is why they're in that environment. In a Schiehallion patient, you might not want to wait to start treatment if you suspect an infection, because by waiting, they'll become more unwell in the interim, so treatment would start as soon as there was suspicion such as raised temperature. There were conversations with Clinicians, Microbiology and IC teams about how best to manage infections, this is something that would happen regularly.

99. There are several different types of central lines. Some that can be used for several weeks, some can last for a year or several years, it depends on the patient condition and their requirements. You can have a central line which has two, three lumens. This is a type of catheter which allows several different infusions with only one access point on the patient often used in critical care and routinely for short term use. Oncology patients often have a central line called a Hickman line which can be placed through the chest into the superior vena cava, this line is suitable for long term access. PICC lines are long very small bore lines that can last a long time and similarly are inserted into a large vein. Often they will be sited in an arm. They are most likely to be used for administration of small volumes of medicine, like long term anti-biotic use. There are also port-a-caths, which are another Central Venous Access Device (CVAD), which sits under the skin, and is accessed by a gripper needle. The benefit is that there is no external line exposed when IV therapy is discontinued. These devices also last long term and are often sited in oncology patients.

Prophylactic Medication

100. I am not aware of any other wards using prophylactic antibiotics, we did not use these in PICU to reduce the risk of infection from the environment. I know that Schiehallion patients received antibiotic and antifungal prophylaxis. I was not involved in any decision making around this.

Cleaning Process

101. The wards had a schedule of daily and weekly cleaning with a regular domestic. As described earlier there was a good relationship between the ward staff and the domestic staff and there was regular communication between them. It could be regarding patient discharges so that the domestic knew which rooms would need a terminal clean that day. The supervisor regularly visited the ward and audited the cleaning in place. The nursing staff decontaminated near patient equipment as per infection control policies. Following an IMT that took place around the cases of Acinetobacter in PICU, it was decided that extra high level cleaning was necessary. The monitors, ventilator and infusion pumps are mounted on a ceiling pendant. It was noted that the cleaning schedule in place for the pendants at a high level was in and that there was residual dust so a new regime for high cleaning was put in place that was effective. We would have communications with our domestic team in the morning, so we that could share, which bed spaces were going to be empty, which we wanted to use. It made for good work communication between our teams. A parent raised concerns about cleanliness regarding the floor in ward 4B. This was resolved by the domestic services manager with a plan for a new type of floor cleaning device to be used to provide a deep clean and it was facilitated by nurses moving patients rooms to allow for deep cleaning regularly. Within Ward 6A parents were moving rooms regularly for other IC reasons such as the chilled beam cleaning so this opportunity could be taken then.

Impacts

102. Bringing in IPC measures like the extra cleaning, HPV, remedial works and enhanced supervision, had an impact. With the chilled beams being cleaned or any remedial estates works, it meant moving patients into different rooms in the ward.

103. Parents didn’t like being moved rooms frequently as they were often living in this room and acquired a lot of belongings and made the room into their space.

Communication

104. Duty of candour is applied to all incidents involving patients that have caused harm, this includes infections. As far as I am aware this is always done in a timely manner and the implications for their child explained both short and long term.

105. When patients were admitted to Ward 6A/4B they were told a lot of information around their child’s condition. They were orientated to the ward environment including infection control measures that they need to observe to protect their child. Parents were given information about being at home with their child, how to care for any CVAD in situ, how to care for their child and infection control and prevention. This was supported by written patient information as well as being given verbally.

Board Communication

106. As noted before there was a process to communicate any information from the board and SMT to the parents of Ward 6A/4B/Daycare and staff. There are also Core Briefs which is routine monthly communication emailed to all staff.

107. Copies of written communication would be given to parents as well as verbally and would be left for other parents attending the ward or daycare to take for information. On occasion the Facebook page run by RHC would be used for communicating with parents with board communication uploaded onto it.

108. If there was anything in a brief that might need to go to parents or patients then they would have briefings for the staff, patients and parents. We would brief the staff and give them copies of the letter which would be uploaded onto a shared drive for future shifts to be able to access and we (Chief nurse, SCN/myself) would then visit each family and discuss the contents of the letter with them and write in the child's case notes that we had done so. This would be done in Ward 6A/4B and daycare, with further letters left for more family's attending daycare.

109. Ward 6A was visited by Jane Grant and Chairman Brown. They asked how the staff were feeling and what the environment was like to care for patients and families. They would check if there was anything we needed specifically or anything else they could do to help, it was during a visit from the board when staff asked for a play room for patients and parents room for Ward 6A. The board ensured that this was achieved. The ward was also visited by the health minister at the time, Jeane Freeman and the Chief Nursing Officer. They spoke with staff and were concerned with staff wellbeing.

Staff Communication Assessment

110. Staff were regularly communicated with, whenever there was an IMT or whenever there was any information from SMT or board, it would be shared with the staff on shift who would upload a written account to the shared electronic nurse handover for staff on subsequent shifts to access. In assessing the communication, one of the things we'd always said and asked staff all the time was: are you happy with the communication? Is there anything more you want? Quite often the response would be to have better communication but this was a general statement and staff didn't have any thoughts on what else could be done. On the other hand some staff really felt they were being listened to and communicated with. I think that communication between the IMT's/SMT/Board etc and the ward staff was good. The staff concerns were heard and play and parents rooms were quickly commissioned. As was a staff

room to support staff morale by allowing a place for the ward team to be able to relax together and help build the team dynamic. This was along with staff hand massage, yoga classes and access to psychology to improve staff wellbeing.

RHC Safety Huddle

111. The huddle runs twice a day, in the morning at eight o'clock, and in the afternoon at three pm. It would be chaired by the duty lead nurse that day along with the Bed Manager. There would be representation from every ward in the hospital. It follows a very structured format. It's a safety huddle. In-patients were discussed, any patients who were 'watchers', (this was patients that ward staff were concerned about), workforce in each clinical area and if there were any areas of concern for the shift ahead. If an area was short of beds for planned admissions, then a plan would be made to manage the flow of patients etc. It was necessary to address all issues with the aim to make each area safe for the shift ahead. Each clinical area would be given a Red Amber Green rating representing safety status. Any patients who were being discussed as potential watchers would have a plan of escalation in case of deterioration. General services and estates would be present for escalation of any domestic or environmental concerns and any clinical estates issues. This report allowed the senior management team to understand the safety position of the hospital for the shift ahead.

112. Communication is a difficult thing to get right for everybody which is why we tried very hard to ensure we spoke to people in person and that we asked if they had questions. When we had communications to give out and there were people in the ward, we were able to address that directly, to have those conversations and writing the notes. That felt to me like that was getting it right. Even if families are not actually in-patient at the time, they still have a huge investment in the staff, the area, everything about it, because it means so much to them and quite rightly so. That was more difficult.

113. As an in-patient, you would have the information given to you as it happened. As we came out of IMT that's what we would do, we'd get the communication, and we would go round families and we would update them as soon as possible. It was often an evolving situation and we would update with information when we had it.

114. Any additional things that we found out, we would inform the families.

Media Communication

115. On occasions, communications would be prepared in case the media had a query about anything in particular that had changed that we were doing. We would have comms in the background if they were required. There was the television programme that had been made about the ward and there was a request for information from GGC. I don't know about the requests at the time by the television maker. I know afterwards, there had been a request from one of the parents for a response from GGC regarding some questions they and other families had about the programme.

116. Ward staff were informed that the TV programme was going to be aired and what time, and that there was support for them if they wished to discuss any of the issues, with either myself or the chief nurse. I went onto the ward the following day and spoke to staff, but there didn't appear to be an issue with staff morale following the broadcast.

Communications between Staff and management, with Patients and Families

117. Communications between patients and families and staff, was something that the nursing staff used to manage. Written communications were shared that were handed out to parents. Some parents appreciated having written responses. After IMTs, there was a system for communication. If information came from the Scottish

Government, from Craig White, from IMTs, anything that affected the whole population of Schiehallion that had to be communicated.

118. Staff were informed first. There had been occasions where media releases had gone out and patients and parents had been told prior to staff, which made it challenging for staff when being questioned if they were unaware of the current position. There was a learning from that and staff were communicated with immediately prior to discussions with families and media releases.

119. Day to day, being in the ward every day, I would always walk around, make sure everybody was okay, speak to some patients, some parents. If anybody did have anything that concerned them, it was possible to speak to them there and have ad-hoc communication.

120. Ward staff were looking forward to moving back to Ward 2A/B to access the specially designed area to help them care for their patients. I was aware that the project was extended, but I have no further information on the re-fit of the Ward/s.

Facebook Groups

121. There was the official Facebook group run by the hospital and the unofficial group run by some families. The media team all had access, the SCN's in 6A, me, the CN, the General Manager and the Patient Services Manager.

122. Around COVID there were some things where the families all had generic queries around the safety of their children and didn't have direct access to ask someone as their child was either not an inpatient or not attending day care regularly and the Facebook group allowed those families to have a quick response to a query.

123. We always invited parents onto our official Facebook group because it was a good adjunct to communication. The parent led Facebook group sometimes caused

parents and families distress due to the content of the posts on that forum. Some families told me that they removed themselves due to how it made them feel and that they felt they got good communication from the ward or RHC run Facebook.

124. After an IMT staff would be updated and then we would update parents if there was relevant information then we could share it. I am not sure how information got from the IMT, to be written up by the communications team. I wasn't included in that process.

NHS GGC Corporate Communications team

125. I had no role in the NHSGGC Corporate Communications team.

Specific Document Communication Examples

(A39355086 – Press statement from NHS GGC on bacteria concerns dated 23 March 2018 – Bundle 5 – Page 131) and (A39123924 – Email from Angela Johnson to all senior staff nurses subject: Water Incident updated 28.03.18 dated 28 March 2018 – Bundle 5 – Page 132).

126. I don't remember seeing these documents however, my name appears on the recipient list in regard to the email.

127. Media statements were not routinely emailed to me. Only if it was possible that I might need to forward onwards to inform staff what would be released in the media or what was a 'holding' statement in case any response was likely to be required. Whenever I was ever given media statements, it was something I would email to the SCN and have her discuss with the staff.

128. I have been shown the following documents:
(A39123885 – Update for parents on ward dated 7 June 18 – Bundle 5 – Page 142).
(A39123918 – CWH8 Poster, referred to as poster for hand wash basins in Bundle 5 – Page 143).
(A38662234 – Update for parents on cleaning dated 13 June 2018 – Bundle 5 – Page 144).

129. These would be examples of standard communication when I was in the hospital which would come with a full discussion and an attachment.

130. We had Bee Safe Posters – Helping to Keep Your Child Safe from Infection which were displayed in every room in Ward 6A. (**A39123933 – Poster for parents titled "Helping to keep your child safe from Infection" version 5 dated September 2018 – Bundle 5 – Page 147**).

131. I have been shown a number of communications relating to IMT from September 2018. However, I was not responsible for Schiehallion at this time and have no comment.

(**A41519618 – FAQ QEUH Ward 6A – Bundle 5 – Page 365**)

(**A41519619 – Letter for parents dated 9 September 2019 – Bundle 5 – Page 366**).

132. These documents were circulated around the time we closed the ward to new admissions.

133. We would have distributed the document in the same way as I've explained previously.

Letter from Kevin Hill (**A41501454 – Letter to parents on ward 6A dated 12 November 2019 – Bundle 5 – Page 382**)

134. We left copies with day care and followed the usual process with inpatients in Ward 6A and 4B.

Letters from Jane Grant to Patients and Families

(A39123935 – Letter Heamato-Oncology Unit 6a dated 14 November 2019 – Bundle 5 – Page 383).

(A39123910 – Parents Letters on Plans to Reopen Ward 6A No 1 – dated 21 November – Bundle 5 Page 395)

135. I think these would have been distributed as before and they might have even been put on the Facebook page for wider sharing.

Oversight Board / Independent Review / Case Note Review / Public Inquiry

136. I was not involved in the independent review or case note review.

137. The process for being involved in the Public Inquiry, has been challenging due to the amount of time taken to complete my statement and the time taken between oral evidence and written statements which has been almost a year if not longer. There has also been a lot of repetition in questions which has taken a lot more of my time that was necessary. It's going to take time to investigate and that is understandable, however individual process has been very challenging to achieve my statement. I'm happy to give any time that's required for this process because I know how eagerly awaited the case note reviews were for affected parents and it will be the same for this inquiry. If it gives any peace of mind that lessons can be learned and similar events will never happen again then it will be invaluable.

Concluding Comments

138. I don’t think the events have had any particular kind of impact on me personally. It’s just part of life and you have to learn from it and move on and find out the best things we can do to make sure this never happens again.

139. I believe that the facts stated in this witness statement are true. I understand that this statement may form part of the evidence before the Inquiry and be published on the Inquiry's website.