

Renal nursing at Sydney Hospital in the 1970

Anderson, G. (2009) Historical reflections: Renal nursing at Sydney Hospital in the 1970s.
Renal Soc Aust J 5(2) 63-65

Submitted January 2009 Accepted May 2009

Abstract:

Pioneering renal nursing was undertaken at the Sydney Hospital in the 1960s and 1970s. Renal nursing courses were developed in these early years to provide education and training for renal nurses. Early experience with arterio-venous shunts, fistulae, haemodialysis, peritoneal dialysis and transplantation are provided from the nurse's perspective.

"...as a bonus registered nurses didn't have to wear veils"

I was drawn to Sydney Hospital having completed a short term in the Casualty Unit during the late sixties as a requirement for my nurse training at St Lukes Hospital. I perceived that the hospital had a very acute focus, great camaraderie and as a bonus registered nurses didn't have to wear veils! It was in the mid seventies that I presented myself to Sydney Hospital to inquire about positions as a registered nurse.

Traditionally renal units had been difficult to staff and Sydney Hospital was no exception. So it was to the renal ward (Ward 17) that I was allocated despite having made it very clear that I had absolutely no experience in renal nursing. Privately I wondered how much interest I had in this area of nursing.

Life has a way of challenging us as individuals and by so doing moulds our futures in ways we do not anticipate. So it was with me working in the Renal Unit at Sydney Hospital. Ward 17 was the old style Nightingale Ward with beds stretching along both sides of the long ward. There were approximately 30 beds with a female and male ward separated by the hospital lift and stairs for the main block. There was often a

mix of male and female patients at either end as beds were always limited. The case mix was acute haematology and nephrology with 3 side rooms with UV light anterooms and Lamina flow beds for reverse barrier nursing. The ward was very busy the usual staff allocation was 2 registered nurses on the morning shift and often 1 registered nurse, sometimes 2 on the evening and night shifts, the remainder of the staff consisted of first second and third year student nurses. My orientation to the ward included 2 days supernumerary, my next shift was the evening shift as the sole registered nurse.

My first patient handover I remember well as I was confronted by diagnosis such as "creation of AV fistula" or "insertion of AV shunt". In my limited experience; a fistula was an abnormal passage between 2 organs or organ and surface of the body. I was shown an external shunt which consisted of cylindrical tubing placed in a vein and an artery and the 2 pieces joined together by a connector. This was separated for the patient to be connected to the haemodialysis machine. I learned swiftly how to reconnect shunts should they come apart and insert T connectors when they required constant infusion

Key Words

history, kidney, renal, nursing, dialysis, transplant

of heparinised saline to prevent clotting. It was a patient who talked me through the latter procedure on my first evening shift. I placed the 2 little metal clamps either side of the connector as instructed by my patient, separated the tubing only to see the blood from the arterial side of the shunt shoot up towards me and the ceiling, luckily we wore sterile gowns for these procedures. I panicked however my patient remained calm; he clamped the tubing with his fingers whilst giving me direction on the correct application of a shunt clamp! My memories are that blocked shunts were a constant problem and as registered nurses we appeared to expend large amounts of our time attempting to unblock them with long intravenous catheters.

Peritoneal dialysis was a major component of the ward work. Soft peritoneal catheters were inserted under a local anaesthetic in the operating theatre, the catheters were used immediately when patients returned to the ward. The protocol called for 3 quick in and out exchanges; each bag had a "drop" of heparin to prevent the catheter from blocking. It was not unusual to have blood in the exchanges for some time and most often the catheters leaked around the insertion site and/or had poor drainage. Rolling and moving patients to assist drainage was not unusual for each drain period, this was demoralizing for

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patients and time consuming for staff. Hard plastic catheters were often inserted for acute peritoneal dialysis. These were inserted on the ward via a long metal trocar; they were used immediately and most often leaked around the insertion site. These catheters were painful for the patient as there was a long piece of the hard catheter external to the body which of course caught on the bedclothes causing pain. This was despite our valiant efforts to support the catheter with a paper cup! Peritoneal exchanges were of 1.5 hours duration including the half hour drain time. The drainage was collected in big plastic containers which when full had to be man or woman handled to the pan room to be emptied.

I 'honed' my problem solving and assessment skills during my time on this ward. It had a very acute focus as a major world renowned renal unit. I felt constantly challenged and motivated with a thirst for knowledge. There were some very competent registered nurses on the ward and I learned a tremendous amount from them. I was confronted with constant acute admissions and acute emergencies. At this time I also met Lynne Richards who had recently arrived from Wales. Lynne commenced on the ward at approximately the same time as me and together we attempted to master the intricacies of renal nursing.

After approximately 6 months of working in Ward 17, Lynne and I were approached by Sylvia Martin the "Charge Nurse" who told us there was a vacancy in the renal course and our names were now on the list. I was unsure if renal nursing was to be my future specialty however I was certainly enjoying the ward and as they say never let an opportunity pass you by. Lynne and I decided we were "up for the challenge".

The Nurse Educator for the renal course at this time was Valda Wiles, a lady whom I discovered was a wonderful clinician, teacher and mentor. Valda had a vision for the future of nursing and a philosophical way of thinking that



L-R: Unknown, Unknown, Lynne Richards, Gill Anderson

enhanced my nursing practice. It was Valda who approached me to give my first conference paper and supported me in developing the paper and appropriate resources. As Valda was presenting at the same conference I also felt her support through the presentation experience and through observing her I also realized the experience and art of networking at such events. I count myself very privileged to have been exposed to her mentorship at such an early stage of my career.

Lectures for the course were held one day per week and we were very fortunate to have renal consultants and Registrars giving many of the lectures. John Mahony and John Stewart would ask constant questions both in the lectures and on ward rounds which were a great learning experience for both the interns and the nurses, although a little daunting at times. Prior to completion of the course and after written papers were completed we all had to pass the dreaded Oral Vivas. The examination panel consisted of 2 to 3 external Nephrology Consultants. I remember my anxiety sitting outside the examination room awaiting my call, my friend Lynne sat on the floor placidly knitting; she appeared

very relaxed! The questions from the panel were probing and extensive looking not only for theoretical knowledge, but analysis and problem solving.

During the renal course we were expected to rotate through the ward, inpatient dialysis unit and transplant unit whilst attaining clinical competence in all areas.

My second course rotation was to the Dialysis Unit. The Unit affectionately termed the "verandah" consisted of 6 to 8 trolleys or chairs on a narrow verandah outside Ward 17 which catered for both inpatient and outpatient dialysis. Lynda Moynahan was the Charge Nurse at the time and Liz Yuill was a senior RN in the Unit. Both Lynda and Liz were consummate dialysis nurses; their cannulation skills were amazing and only exceeded by their patience with me as I struggled with my own ineptitude in learning to cannulate AV fistulae. All dialysers were washed and soaked in formalin by the dialysis nurses prior to reuse, the aim being to achieve as many uses as possible for each patient. I remember my first cardiac arrest on the verandah where placing the patient on the floor whilst allowing room for the arrest team was a very cramped and

interesting experience. The unit was very busy and had limited resources for long term treatment of patients. I struggled with the ethical issues of resource allocation and the decisions that were made relating to who should receive such limited and valuable resources.

My final rotation was to the Transplant Unit which I found challenging, confronting and enjoyable. Mary McGuirgan was the Charge Nurse at the time. Mary was and still is an excellent clinician, she ran the unit with amazing precision and was held in very high regard by all. Harvested kidneys for transplant were all placed on a perfusion machine at Sydney University prior to transplantation, there was a higher rate of delayed function due to acute tubular necrosis than exists today. This led to a period, sometimes protracted, of haemodialysis for the patient. All patients were dialysed within the transplant unit using regional heparinisation. This consisted of a double pump which infused heparin pre dialyser and protamine to counteract the effects of the heparin post dialyser. The side effects of this regime could be bleeding and/or patients having an anaphylactic reaction to the protamine.

Transplantation was not as processed and routine as it is in units today and patients remained hospitalised in the unit for extended periods post transplant. Along with delayed function and often due to this; diagnosis of acute rejection episodes was more limited and difficult. The armory to treat rejection was also limited and consisted of first line management of large doses of up to 1 gram of methylprednisolone. The second line management was a course of ALG. The ALG used at this time was a new experimental drug manufactured at Sydney University. My clinical experience using the pharmaceutical

drug manufactured today compared to the initial Sydney University drug was very different in that we saw many more reactions to the earlier drug.

Visitors to the unit were limited to 2 at a time and once daily, once they left the unit they could not return. Similarly the staff was not allowed to leave the unit except for clinical escorts etc. Staff and patients had to wear theatre scrubs masks and gloves; children were not allowed in the unit. This resulted in social and physical isolation for patients and resulted in many psychosocial issues for both patients and families. Patients were told that they were not to have any contact with pets or animals once they returned home and this was a major issue for many patients and their families.

Food preparation and cooking was done by the renal dietician and occurred in the purpose built kitchen directly outside the unit. The food, once cooked was passed through the UV light window directly into the unit. Any food such as lettuce which could not be cooked was soaked in Milton prior to entering the unit. Both patients and staff consumed the food which was delicious with weight gain being a problem for long term staff in the unit.

The time in the transplant unit enabled me to explore another aspect of renal nursing which truly captured my interest. This period initiated my concern and interest relating to the use of advanced technology in the treatment of patients, and the inability to quantify the repercussions on patient and family in a more psychosocial domain.

My time at Sydney Hospital was a very happy and rewarding period in my career. It was far from perfect however always interesting. The Hospital was after all historically the "Rum Hospital" and there were some eclectic personalities

who worked and resided there. I was right about the camaraderie and it was sad to observe the downgrading of the hospital and the transfer of various renowned specialty units to different hospitals.

I remained at Sydney Hospital until it was transferred to Royal North Shore Hospital in the early eighties. During this time I was given the opportunity to work as Second in Charge of Ward 17, Charge Nurse of Transplant Unit and rotating week-end after hours Nurse Manager of the hospital, a requirement of all Charge Nurses at the time. I commenced tertiary qualifications in Education and this remains one of my major areas of interest. I remained within the renal specialty for 20 years and was given the opportunity of establishing the Clinical Nurse Consultant (CNC) roles at Westmead Hospital and became the first Nephrology CNC within NSW. I published on the establishment of the role in 1986. I completed a Masters in Bioethics during which I examined the quality of life of renal patients from an ethical perspective.

Whilst working at Westmead Hospital I met again Liz Yuill who established the Westmead Dialysis Unit, Lynne Richards who established the Dialysis Home Training Unit there and Mary McGuirgan who became the Westmead Bone Marrow Coordinator.

My career was shaped by my incidental placement in the Sydney Hospital Renal Unit and the many staff and patients I met during my time there. I am eternally grateful to you all.