

# Being a nursing student in an Australian renal ward in 1978.

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## Abstract

The student nurses' role in the renal ward was often spent caring for people on cyclic peritoneal dialysis. These people, unable to receive haemodialysis treatments, were awaiting kidney transplants. Although the student nurses' role was very task oriented, they were very important in the early pioneering days of patient care in the renal ward.

*Nurses and home haemodialysis patients had to strip, clean and grease the inside parts of the machine monthly.*

I was a second year student nurse working in the renal ward of the Prince Henry Hospital at Little Bay in Sydney in early 1978. At that time I had just entered the second year of my three year nurse training program at the Prince Henry, Prince of Wales and Eastern suburbs groups of hospitals. The renal ward was situated at Heffron House ground floor and was meticulously managed by the Charge Nurse, Monica Maquire.

My first shift was a Sunday afternoon and I was impressed how quiet the ward was. There were so many empty beds with only a handful of haemodialysis patients who were not allowed to go home as they had shunts which could easily disconnect. Haemodialysis patients lived 'permanently' in the renal ward. A number of large dressing trolleys, strategically placed around the ward, were set up with mysterious equipment and covered by a cream drawsheet. The ward layout was not arranged as a nightingale ward, which was the usual arrangement for the wards at Prince Henry Hospital. On entering the ward, three single rooms were on the left followed by a set of three, four bed alcoves. Along the right side was a series of single beds with only a curtain separating each bed. At the far end of the ward was a double room

with an additional single room annexed off that room. In a separate location at Heffron House ground floor were the haemodialysis unit and the kidney transplant units. As a second year student nurse I was not allowed into these units and thus they remained a mystery to me during my nurse training.

I was very fortunate to be able to start in the renal ward on a quiet evening and was given a very thorough orientation of all the procedures and equipment that was used on the ward by the in charge Registered Nurse. Built into the walls of the ward, were small warming cupboards that were only big enough to hold three, 1 litre glass bottles of peritoneal dialysis solutions. Each bottle had a blue Travenol label with either 1.5% Glucose, 2.5% Glucose or 4.25% Glucose. I was then shown the large warming cabinet that kept the dialysis bottles at a comfortable 37°C and I was told that it was the student nurses' responsibility to keep the warming cabinet fully stocked with warmed dialysis solutions. I did not think that this directive would be a problem considering how quiet the ward was and that the cabinet when fully stocked held over 30 bottles of dialysis solution. I had no idea of the chaos that would envelope the ward the next morning.

## Key Words

history, kidney, renal, student nurse, peritoneal dialysis,

Next morning, I was surprised by the number of both registered and student nurses that crammed into the charge nurse's office for morning report. That first report was unintelligible to me as it was a series of names and unheard of diagnoses. I was amazed at the number of patients who filed into the ward and knew exactly which bed to go to for their "treatment". Then the nursing admissions began with weights and observations. This is the first time I had heard of a "dry" weight.

I then learned that the "treatments" were known as intermittent peritoneal dialysis cycles. Peritoneal dialysis was not offered as a permanent treatment but was used for patients who could not have haemodialysis and were waiting for a renal transplant. Patients would be admitted on a Monday morning and had cycles every hour, on the hour, which lasted until either Wednesday or Thursday, depending on how much fluid they had accumulated since their last peritoneal dialysis treatment. Peritoneal dialysis was only offered as an intermittent regimen for inpatient treatments. Some patients were admitted on the Wednesday and stayed for their hourly cycles until Saturday or Sunday.

The procedure involved the patient being admitted in the usual method and then the patient would expose two long dialysis tubes which had been inserted into the abdomen in a previous

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operation. One long tube was to allow fluid to run into the abdomen and the other long tube was to allow fluid to drain out of the abdomen. The registered nurse had the overall responsibility for the management of the dialysis cycles and the administration of any intraperitoneal medications such as antibiotics into the dialysis solutions. Each registered nurse had responsibility for the management of about 10 peritoneal dialysis patients on each shift.

The role of the student nurse was to perform the peritoneal dialysis cycles but the dialysis cycles could not begin until the registered nurse had connected the dialysis lines to the long tubes in the patient's abdomen. The dialysis lines had two upper lines with spikes, which were spiked into the dialysis bottles. These two lines merged into one line for the running in of the dialysis solution. The second long tube had a drainage bag attached which is where the dialysis effluent drained out.

The regimen was very strict and ran over precisely 60 minutes. Student nurses who allowed their regimen to run late were scolded severely as delays in the regimen delayed the patient completing their cycles and being discharged. So every attempt was made to keep on time. The hour began when the long hand of the clock was on the 12. This was when two 1 litre bottles of dialysis fluid had to run in and the dwell time began. 10 minutes was allowed for the running in. The dwell time started at 10 minutes past the hour and last until 30 minutes past the hour. At 30 minutes past the hour, the drain line was opened and the drain began. The drain time allowed was 30 minutes and often patients would be asked to stand up to make sure all the dialysis fluid drained out. During the last 10 minutes of the drain cycle, students had to connect the new bottles of dialysis solution and have them ready to run in

when the clock hit the 12 again. This last procedure caused enormous angst for both parties as connecting new bottles too early allowed the fluid in the bottle to cool down and the patients would complain bitterly that the dialysis solution was cold. Any complaints by the patients were compounded by the registered nurses' reprimands. So every effort was to connect the dialysis solutions as close the top of the hour to stop the patients' complaints. Sometimes the fluid in the dialysis bottles was too hot so the student had to determine which dialysis bottles were 'not too hot, not too cold but just right!'

Strict aseptic technique was mandatory for each spiking of the dialysis bottles. Students wore face masks and white cloth gowns and used sterile gloves to spike the dialysis bottles. Students virtually spent the shift in face masks and washing hands. In between the cycles, students had to perform the routine nursing tasks such as personal hygiene and take observations. All the patients had sponges as patients were not allowed to get the dialysis lines wet. Attention to the completion of the fluid balance charts was important including the correct calculations for the peritoneal dialysis exchanges.

About 11 am I noticed that some peritoneal dialysis bottles were missing from the small warming cabinets located in the walls of the ward. I had learned that taking these bottles was a last resort and only occurred when there were insufficient warmed bottles in the warming cabinet.

Apart from performing peritoneal dialysis cycles on my patient, I had been given sole responsibility to keep this cabinet fully stocked with warmed dialysis solutions for that shift. I decided to check to see the stock level of the solutions in the warming cabinet. I was

shocked and horrified to discover that the fully stocked cabinet at 7 am was almost empty with only two warmed bottles of solution left in the cabinet. Fearful of the scolding that I would receive if the virtually empty cabinet was discovered by a registered nurse, I quickly restocked with as much peritoneal dialysis solution that I could find and closed the door, hoping that the solution would warm sufficiently enough for the next round of exchanges. I assumed that I had identified and rectified the problem at a critical point as no one came to admonish me that day. After that incident I made it a priority to check and restock the cabinet every hour!

Another duty that was given to the student nurses was the 'fluid round'. This duty required the student to load a trolley with various drinking liquids and proceed through the ward every two hours. Liquids consisted of orange or lemon cordial, water or lemonade. Patients were prescribed as little as 30ml every two hours. On the trolley was a tall burette where fluid was poured into the burette, measured, then poured into the patient's cup. Measurements were very strict and students were warned not to give any more fluid to a patient than what they were prescribed. To quench the patient's thirst, the patients were allowed ice chips instead of fluid and the student battled to get enough ice chips in the burette to reach the prescribed level, not go over and not let the patient feel that you did not give them enough fluid.

In conclusion, I hope this short story has enlightened you to the role of student nurses in the Prince Henry Hospital renal ward in 1978. Student nurses played a major role in the care of the renal patients on peritoneal dialysis with supervision by the nephrology registered nurse.