

was never my thing! The patient was sedated with intravenous pethidine. Local anaesthetic infiltration was used and a tourniquet was applied. An arm board supported the arm and as the assistant I was in charge of tourniquet pressure, sedation of the patient and cutting the stitch ends. I tried not to look. Bill Chan was the registrar and he held my concentration on the job by clamping my knees with his as we sat either side of the patient's arm. Shunts were prone to clot and de-clotting was a regular occurrence. It was a painful procedure for the patient.

Dialysis happened with the technician running the machine and the nurse specialising the patient. Very regular observations were taken - five minutely, I recall. The machine was a huge stainless steel bin of water with additives that the

technician had mixed up with a large paddle. A plastic lid covered the bin when in use. It was so heavy he needed help to manoeuvre it to the patient's bedside. When the bin was empty, dialysis was finished.

Renal failure patients were subjected to the Giovanetti diet. They got rice bubbles with a tub of cream for breakfast, plenty of sugar and black tea or coffee. Consequently their appetite and nutrition was abysmal!

At 4pm every day the doctors congregated in the nurses' station to await the biochemistry results. The laboratory phoned and the nurse wrote them into a large book with the doctors looking over the shoulder of the writer. They then could make decisions for the next day.

Later, when I worked at Flinders Medical Centre there had been excellent progress in a few short years. Dialysis machines had been made more user friendly with closed circuits. However, the peritoneal dialysis with Travenol glass bottles had a nasty habit of breaking and the sticky fluid took some time to clean up. Peritoneal dialysis was by way of temporary catheters which were removed after 48 hours of therapy and treatment comprised of one hour cycles of 20 minutes fill, 20 minutes dwell and 20 minutes drain.

Thankfully there have been significant changes to the equipment and procedures which have led to a safer environment for both patients and nurses.

Peritoneal dialysis bags, water and stick catheters

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Abstract:

In the early 1980s peritoneal dialysis at the Austin Hospital in Melbourne was very different from the 2000s. It involved many bags, stick catheters and frequent dialysate leaks.

Often the trickling dialysate effluent could be seen and squelched down the hallway

Chris graduated in 1981, completed a three month rotation at the Austin Hospital Renal Unit and then returned as a graduate in 1982. Meredith had been working as a registered nurse on night duty for eight years. We both finally worked together on Ward 3, located in the now demolished A Block. Nursing was very different in those days; patients

all had a daily rest with no interruptions, no-one entered the ward without permission from the staff member in charge, and it was the nurse's responsibility to create a very tidy and clean environment for the patients. The ward was run with 'military precision' and the Director of Nursing at that time regularly conducted ward rounds without notice.

Key Words

history, renal, nursing, peritoneal dialysis

The haemodialysis unit was located on the balcony of Ward 3. There were six chairs and the main form of communication between the ward and the dialysis unit was via a window!

The first treatment option for those patients with acute renal failure was acute peritoneal dialysis via a 'stick catheter' The nursing staff on duty would receive a call from casualty that a patient with acute renal failure would be coming to Ward 3. At this point the 'action plan'

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was implemented. Into the steri-room or Room 14 if available, we went. We collected all the equipment and machine which often had a mind of its own when wheeling it out to set up. Supposedly it was a very simple machine but 'not user friendly'. Equipment consisted of a 'stick catheter', basic tray, dressing towels, local anesthetic, gown, gloves and mask, betadine, tape, peritoneal dialysis fluid, peritoneal dialysis lines with a 'Y' line and a heating coil and link sets. When we say peritoneal dialysate fluid we are talking 20 two litre bags.

Somehow we managed to line all the peritoneal dialysate bags up, pierce them, detangle the link sets and then you were ready for 'action'. If you happened to puncture the sides of the bags you had to start all over again. We were often reminded about wasting supplies and making a mess! You can imagine the sticky floor. It took two staff to actually 'hang the bags and link sets' in order. This process usually took 20 minutes.

Inserting the stick catheter was usually done by a consultant nephrologist with a registrar in attendance. No ultrasound technology in those days just good old fashioned 'touch and feel technique'. If the fluid return after insertion was clear, you knew you were successful however, if it was stained brown, (faecal fluid) you knew the patient was in trouble.

Taping of the peritoneal dialysis stick catheters was an 'art form' and only a selected few were chosen to perform this task. Once connection to the machine was completed, you held your breath, until the fluid all flowed in and out with no leaks. The heating bath was a peritoneal dialysis line coiled and inserted into a container of warm water. The temperature of this bath had to be maintained exactly at body temperature which was not always easy to achieve. The drain-out bags were emptied into drums which were measured 12 hourly and ongoing fluid calculations were completed and the orders for the next 12 hours were given. We tested the

initial drain out volumes into a cylinder which only had approximately a five litre capacity. You can imagine the floor when busy nurses forgot to empty it or re-attach the drain out bags to the drum. Often the trickling dialysate effluent could be seen, and squelched, down the hallway. Even though this form of treatment seems archaic, patients did very well and usually survived their acute episode of renal failure.

Ward 3 nurses were a great team and delivered five star quality care. The order of the day was, physiotherapy at 10am, rest period 11-12 am, sitting out of bed 9am – 11am, no visitors until 2.30pm and best of all hair washing and nails to be done on Sundays. These were some of the rules that patients adhered to sometimes reluctantly but invariably were very appreciative when they were discharged. Today's patients can only dream of receiving such care.

Great friendships remain from those days on Ward 3.

Continual ambulatory peritoneal dialysis in the 1980s

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Abstract

In the late 1970s and 1980s, the introduction of continual ambulatory peritoneal dialysis in Australia gave people suffering from kidney disease another treatment option. Although techniques appeared crude, nurses responded to the clinical challenges developing models of care to meet patient needs while maintaining multidisciplinary collegiality and teamwork.

I recall when 70 was 'old' and caused comment and discussion about the wisdom of starting dialysis.

The 1980's were an exciting time to be working in continual ambulatory peritoneal dialysis (CAPD). The technique

of CAPD was described by Popovich and Moncrief (1976) and the United States Food and Drug Administration (FDA)

Key Words

history, renal, peritoneal dialysis, haemodialysis,

approved polyvinyl bags for use in 1978. The earliest patients in Australia that I am aware of started CAPD around 1979 when the polyvinyl bags replaced glass bottles for Travenol solutions in this country.

When I started working in the Renal Unit at Royal North Shore Hospital

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