As My Nursing Career Draws to a Close

Having worked in the nursing profession for almost thirty eight years my retirement will be in the not so distant future. I have seen a lot of changes in nursing over those years.

When I graduated in 1973 a full time Registered Nurse was making $580.00 per month. In 1974 SUN (Saskatchewan Union of Nurses) was formed. This gave nurses a bit of power over their employment. The first contract paid a general duty nurse $4.08- $4.75 per hour. It was a small step in gaining wage equality with other groups. The Union has helped us keep up with the rising cost of living and tried to improve our working conditions and salary with each new contract.

Other changes have been the evolvement of cardiopulmonary resuscitation. Working on a medical floor my first year out of training I remember a patient having a cardiac arrest and the orderly had him on the floor and was pumping his arms up and down. I'm not sure what the theory behind this sort of treatment was and I don't believe it was effective. In 1974 they began teaching us CPR as we know it today and the guidelines have evolved throughout the years. My first certification in CPR was done on a resuscitation doll that could measure the depth of your breaths and could time your compressions on a printout graph. You started with four stacked breaths and then compressions followed by two breaths for every fifteen compressions. Everything had to be very precise in order to pass. The guidelines have changed over the years and now we are putting more emphasis on compressions and defibrillating at the earliest time if indicated. The outcomes are being studied to see if this is actually improving the survival rate.

Another big change that I have seen is in the delivery of analgesic medications. Patients who were post surgery or NPO and required analgesics for pain were given intramuscular injections every four to six hours. In 1982 the patient controlled analgesia pumps or PCA were becoming popular and patients could have more control over their pain by self administering their analgesics. This is so much nicer for patients not to be continually poked and not having to wait for a nurse who would sometime be busy and not be able to give the injection when it was due. Intramuscular injections have become much less frequently required.

The administration of antibiotics has also changed. We did give antibiotics by a mini bag but they were attached on a normal y intravenous set and you had to time the infusion to change the mini bag back to the main intravenous. No one had thought to let gravity assist us by elevating the mini bag. This helps prevent the intravenous from becoming plugged if it wasn't changed over after the antibiotic was through. We also used an infusion pump to give antibiotics that were pre mixed in a syringe by a pharmacist.

Hospital stays for surgery have decreased considerably. In the 1970's the patients would be admitted the day before their surgery. They would have a pre op bath with an antiseptic soap. Anesthesiologists would do a pre op visit on their patients if possible. Following that visit they would prescribe a pre op medication in the form of a hypodermic injection. It would be an analgesic and something to dry

mucosal secretions, Demerol and Atropine was a common combination. We would administer these injections one hour before the booked time of surgery and as you can imagine, timing could become a problem. These pre ops were discontinued later on as they were proved not effective and as anesthetic drugs improved they were not required. After surgery patients would remain in the hospital as least one to two days and more likely three or four. This made it a nice mix for the nurses as they could count on some patients requiring minimal care which would allow them to spend more time with those needing a lot of nursing care. Now a high percentage of patients are admitted the day of surgery and many also go home the same day just a few hours after the procedure. Today most of the patients in hospital are very ill thus making the load very heavy and I don't think the staffing ratio reflects this high acuity as much as it should.

Nursing has become very technical, equipment has become very complex and is changing every day as second and third generations are manufactured to improve patient outcomes and decrease surgeons' operating times. It is rare to work a day when you don't learn something new.

Diagnostic tests have also become very detailed with CT scanning, MRI's and Pet scans. With all this sophisticated diagnostic and surgical equipment comes a big price tag. Medicine has become very expensive.

We use a lot of disposables and that creates a lot of waste. Even laparotomy sponges and drapes were washed and reused when I first started working in the operating room. Senior nurses that I worked with at that time told me about how they would wash, repowder and resterilize the surgical gloves. Certainly I think it is a lot safer to have disposable sponges and gloves, but we may be using too many disposable items which may not always be cost effective and probably not good for the environment. Some OR's are trying to become greener but I believe we have a long way to go. A few companies have started reprocessing single use items. The items are basically taken apart, cleaned and rebuilt then sent back to the hospital for reuse. This is supposed to save some costs and decrease wastage.

I am happy with my chosen profession as a nurse. Nursing comes with a lot of invaluable knowledge that we use every day at work and at home. It gives us a lot of flexibility in our schedules that you may not get in other careers. We work with amazing people who teach us things every day. And best of all we get to move as we look after our patients and I really think that is better for the body than sitting at a desk all day. We go home tired some days, but hope that the care we have given has made a difference by helping ease a patients' anxiety, or made their surgery or procedure as pleasant as it could be, then we have done our job.

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