



IN THIS ISSUE:	PAGE
Negotiations with RAV/AAV	1
The roles of PERS Consultants and Coordinators	1
Shepparton SCN Refurbishment	1

Negotiations with RAV and AAV

In response to requests, especially from rural maternity units, that we assist them with organizing timely transport of women to metropolitan hospitals for care, I've met in recent months with MAS, RAV & AAV staff, and we've collectively developed a process to make this possible.

The issues have been that in some small rural units all available clinical staff are fully occupied in caring for the pregnant woman and so have difficulty in leaving to make a series of phone calls to arrange their transport. In other cases transport has been booked by the rural hospital but unforeseen delays in arranging either air or road transport have led to adverse events. In retrospect, in some cases, had the likely delay been appreciated at the time of the PERS consultation, it may have been better to plan delivery on-site and send the NETS team out to retrieve the baby!

The process: especially for time-critical cases coming from rural sites, the AAV controller can be invited into the initial conference call, listen to the clinical scenario and the advice provided, and will be able to provide 'real time' information regarding the availability of air and road transport. The booking process can be commenced during that call, with no further need for the referring hospital to contact RAV/AAV.

It is not mandatory for hospitals to avail themselves of this service – but PERS staff need to anticipate the need for timely transport when receiving calls from rural areas about possible time-critical cases. If needed, connect the AAV controller into the call so their input can be factored into developing the best clinical plan. Alternatively, for other urgent (but not time-critical) transfers, ask the referring clinician at the conclusion of the call if they would like PERS to arrange the transport, or would prefer to do it themselves.

The PERS consultant is responsible for clearly communicating the urgency of transfer. AAV/RAV have undertaken to contact us should there be any substantial hold-ups with transport, and in some cases it may be appropriate to review the management plan with the PERS consultant.

There is also an 'escalation protocol' to enable rapid resolution of any problems to be undertaken by PERS and AAV/RAV management. Please [follow this link](#) to view the final draft of the agreement between PERS/RAV/AAV. I'd be appreciative of any feedback. Please send your feedback to jacqui.smith@rwh.org.au

SHEPPARTON SCN REFURBISHMENT

Dr. Bruce Warton, Chief Medical Officer at Goulburn Valley Health, has advised that refurbishment of the Shepparton SCN will commence on the 14th January 2008, and is anticipated to be completed by 10th March.

During that time, their capacity to care for unwell neonates will be limited to only 2-3 SCN cots, so they will require assistance with both in-utero and neonatal transfers. They will also seek to transfer all women presenting in labour prior to 34 weeks.

PERS Consultants and Coordinators

I've been asked by several of the PERS consultants to provide some updated information on the respective roles of the PERS consultant and the PERS co-ordinator.

As you are aware, PERS has been set up to fulfill a number of functions – to provide 24x7 access to consultant obstetric advice to maternity service providers throughout the state, to assist in arranging a bed for women who need to be moved between sites to enable them to access optimal care, and to provide an easy point of access for a range of clinical information and educational resources of use to clinicians.

Given the limited availability of specialists and procedural GPs now at many rural and outer metropolitan sites, some of the referral calls may come directly from midwives working without medical staff on-site, or from junior medical staff with very little prior experience in obstetrics. PERS nevertheless has a statewide responsibility to provide access to consultant obstetric advice for all clinicians providing care to maternity patients.

Of the 12 PERS co-ordinators currently working on the roster, around half come from a senior midwifery background, and the remaining are from a neonatal nursing background. That being said, many of the neonatal nurses have qualified as a midwife in the past (although may no longer have current practicing experience in the area) – but some have trained exclusively in ICU and/or paediatrics prior to their neonatal nursing training.

Therefore I would expect that the amount of input required by the duty PERS consultant in particular cases and/or with particular co-ordinators may vary from minimal through to needing to be conferenced into every referral call. I understand that that was not the expectation when the service started, and it was anticipated that all of the co-ordination shifts would be covered by experienced midwives, providing a buffer between the routine and less-contentious referral calls and the duty PERS consultant. Although the total number of referral calls each day is still usually not great, I appreciate that it is work performed in addition to the PERS consultants' usual clinical load, so the extra calls that occur on some days may affect your decision to continue on the PERS consultant roster. If this is an issue for you, please contact me directly to discuss it further: jacqui.smith@rwh.org.au or 9344 2775

From my perspective, I believe it is essential that the co-ordinators feel confident that they can access support from the duty PERS consultant whenever they feel the need, and especially when they believe they are moving outside their own scope of practice.

Jacqui Smith