Diabetes Specialist Nurse Service Clinical Prioritisation Tool

A companion document to the Community & Allied Health Access Framework

The demand for regional Local Health Network (LHN) Community and Allied Health Services has grown in recent years and is expected to continue to rise. In this context, all efforts must be made to create and maintain equitable and safe access to state funded health services.

Regional LHN profession / discipline networks have drawn upon state, national and international reference material to design clinically relevant prioritisation criteria. Clinical prioritisation criteria will help ensure consumers that are referred for public health services are risk assessed in order of clinical urgency.

Services for Australian Rural and Remote Allied Health (SARRAH) describe prioritisation as 'the ordering or sequencing of individual patients based on need (deciding who needs to be seen first, rather than a 'first in first served' cuing system)' (SARRAH 2013).

Clinical prioritisation criteria provides guidance to clinicians to support clinical decisions within regional LHN prioritisation processes and should be uniformly implemented across programs. Clinical prioritisation is to be applied when there are:

- New contacts
- New episodes of care
- Waiting list reviews
- Significant changes in a client's condition.

Equity

Health professionals contribute to an accessible health care system where people, regardless of their individual social, cultural, linguistic, religious, spiritual, psychological, medical and care needs receive respectful and inclusive health care services.

Health professionals recognise the unique needs of:

- people from Aboriginal and Torres Strait Islander communities
- people from culturally and linguistically diverse backgrounds
- people who are financially or socially disadvantaged
- veterans
- people who are homeless or at risk of becoming homeless
- care leavers
- parents separated from their children by forced adoption or removal
- lesbian, gay, bisexual, queer, transgender and intersex people.

Clinical Prioritisation Elements

The key components in the quality clinical prioritisation process for application in regional LHNs are:

- guiding principles
- clinical reasoning support systems
- clinical prioritisation tools.

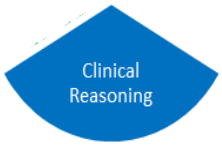
Guiding principles

Within the context of clinical prioritisation the following principles apply:

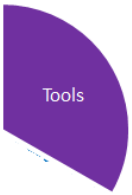
- risk minimisation is the highest concern
- all client referrals are to be treated with respect
- the collection of critical clinical information is essential
- not all health needs have to be met via regional LHNs services.

Clinical reasoning

The process of clinical prioritisation is based on clinical reasoning. Clinical reasoning is a core competence of all health professional staff. Clinical governance structures within regional LHNs support the ongoing application of effective clinical reasoning through reflective practice. In order to provide safe, quality services, some services will need to be provided according to evidence based timeframes relevant to clinical presentation.



Clinical prioritisation tools



Regional LHN clinical program areas should maintain best practice clinical prioritisation tools. These tools provide guidance to support clinical reasoning. The tools may take a multi-disciplinary or a single discipline approach and use clinical indicators to differentiate between high risk and lower risk. For many regional LHN programs, these risk ratings are aligned to four levels of priority, however some programs will use less levels. In addition to clinical prioritisation tools, there may be a range of other clinical tools that can be used to assist clinical reasoning (for example, screening, triage and best practice clinical guidelines).

Supporting Clinical Prioritisation

Relevant clinicians (or staff acting on their behalf) are required to obtain clinical information that will assist in assessing the immediate and long-term risk for the client. This critical information becomes the basis on which clinical priority is allocated. This information may be comprehensively provided by the referrer or may require contact with the client, or a representative, or may require the gathering of information from another health care provider (for example a GP). It is the responsibility of each LHN to establish practices that ensure referrals received are able to be clinically prioritised in a timely manner.

Externally Funded / Revenue Services

Externally funded (non-core) service referrals should be allocated according to funded agreements in place. In these circumstances, clinical prioritisation criteria may be useful in assisting regional LHNs to manage demand during service contingencies within professions / disciplines.

Typically, non-core services include My Aged Care (CHSP, HCP), DVA, NDIS, ACAT, Compensable / Workcover, return to work and occupational rehabilitation, and Local Health Network based NGO service agreements.

DIABETES SPECIALIST NURSE SERVICE CLINICAL PRIORITY TOOL				
	Any diabetes type	**Type 1 diabetes**	**Type 2 diabetes**	**Gestational Diabetes**
URGENT Requires immediate medical assessment, SAAS or presentation to emergency department	• **Vague/confused/altered state of consciousness.** • **Poor historian/difficult to assess when not physically present.** • **Inability to self-care / absence of carer.** • **Not tolerating oral food or fluids / persistent vomiting.** • **Hyperglycaemia / prolonged hyperglycaemia** (e.g. blood glucose (BG) greater than 15.0mmol/L and or blood ketones (BK) greater than 1.5mmol/L despite treatment). • **Severe hypoglycaemia / prolonged hypoglycaemia (**e.g. BG less than target despite treatment).	• **Diabetic ketoacidosis (DKA)** (e.g. hyperglycaemia, BK greater than 1.5mmol/L and/or dehydration and/or symptoms of nausea, vomiting, and abdominal pain, increased ventilation and/or deep rapid breathing. • **Insulin pump failure** (e.g. no insulin delivery). • **Paediatric** (e.g. new diagnosed). • **Pregnancy** (e.g. high risk of maternal and/or fetal morbidity).	• **Hyperglycaemic, hyperosmolar state (HHS)** (e.g. hyperglycaemia, hypotension, tachycardia or irregular heart rate and/or symptoms of nausea, vomiting, abdominal pain, hyperventilation, lethargy and/or anxiety. • **Paediatric** (e.g. new diagnosed). • **Pregnancy** (e.g. high risk of maternal and/or fetal morbidity).	• **Risk of miscarriage/stillbirth** (e.g. backpain, contractions, pv loss, decrease in signs of pregnancy/fetal movement).
Priority 1 Risk of hospitalisation or adverse outcome for the client **Timeframe:** Within 24-48 hours	• **Inpatient consultation** (e.g. assessment and discharge planning). • **Recent SAAS Call Out** (e.g. assessment and prevention). • **Outpatient consultation** (e.g. rapid response, case conference, omitting insulin or incorrect diabetes medication or dose (e.g. overdose). • **Prolonged or recurring hypoglycaemia** (e.g. BG less than target after two hypo treatments). • **Risk of severe hypoglycaemia or hypoglycaemia unawareness.** • **Recent diabetes related hospital admission.**	• **New diagnosed.** • **Advanced hyperglycaemia** (e.g. BG greater than 15.0mmol/L, BK greater than 0.6mmol/L, correction doses of insulin). • **Risk of DKA** (e.g. intercurrent illness, recent DKABK greater than 0.6mmol/L). • **Equipment failure** (e.g. insulin pump or pen, BG/BK monitor). • **Paediatric.** • **Pregnancy** (e.g. antenatal medication management, postnatal medication management).	• **Advanced hyperglycaemia** (e.g. BG greater than 15.0mmol/L for more than 24hour). • **Risk of HHS** (e.g. intercurrent illness). • **Equipment failure** (e.g. insulin pen, BG monitor). • **Paediatric.** • **Pregnancy** (e.g. antenatal medication management and commencement of insulin therapy, postnatal insulin medication management).	• **Commencement of insulin therapy** (e.g. basal and/or meal time).

Priority 2 Risk potential for short or medium term high level harm **Timeframe:** 3-7 days	• **Risk of moderate hypoglycaemia and hypoglycaemia action planning** (e.g. hypo action plan with/without GlucaGen Hypo Kit). • **Hyperglycaemia action planning** (e.g. sick day management plan).	• **Ambulatory insulin titration** (e.g. changes to insulin therapy, insulin pump settings, basal and/or meal time). • **Equipment upgrade** (e.g. insulin pump, BG/BK monitor). • **Paediatric.** • **Pregnancy** (e.g. antenatal and postnatal insulin titration).	• **Commencement of insulin therapy** • **Ambulatory insulin titration** (e.g. changes to insulin therapy, basal and/or meal time). • **Paediatric.** • **Pregnancy** (e.g. antenatal and postnatal medication management titration).	• **Ambulatory insulin titration** (e.g. changes to insulin therapy, basal and/or meal time). • **Newly diagnosed.** • **Day 4 Post-natal follow up.**
Priority 3 Risk for long term harm, but have good chance of improvement **Timeframe:** 8 days - 1 month	• **Recurring mild hypoglycaemia and hypoglycaemia action planning** (e.g. hypo action plan with/without GlucaGen Hypo Kit). • **Changes to hyperglycaemia action planning** (e.g. sick day management plan). • **Diagnosis of complication or co-morbidity** (e.g. renal disease, CVD, neuropathy, change in foot risk, retinopathy). • **Professional continuous glucose monitoring (CGM) (e.g. 2 week trial).** • **Pre anaesthetic medication plan.** • **Aged care assessment.** • **DECD training** (e.g. new diagnosis, changes to care plans, school excursion and camp guidelines).	• **Ambulatory insulin titration for overseas or domestic travel** (e.g. changes to insulin pump settings, basal and meal time insulin therapy). • **Basal bolus insulin calculations** (e.g. insulin:carbohydrate ratio/s, insulin sensitivity for correction). • **Equipment upgrade** (e.g. CGM). • **Paediatric** (e.g. returning to school/childcare, changes to care plans, school excursion and camp guidelines).	• **Newly diagnosed, HbA1c 8% (64mmol/mol) or more** (e.g. T2DSCP). • **Commencement of medication with risk of hypoglycaemia** (e.g. sulfonylureas and/or insulin). • **Commencement of medication with risk of euglycaemic ketoacidosis** (e.g. SGLT2 inhibitor). • **Paediatric** (e.g. returning to school/childcare, changes to care plans, school excursion and camp guidelines).	
Priority 4 Risk for long term harm, low level immediate complications **Timeframe:** 1 - 3 months	• **Personal CGM acquisition and training.** • **Residential aged care** (e.g. admission assessment). • **DECD childcare and schools training** (e.g. Level 3 training for teaching and/or support staff). • **Health careworker training** (e.g.NDIS carer). • **Residential aged care (e.g. annual review).**	• **Commencement of insulin pump therapy.** • **Upgrade of insulin pump therapy.** • **Paediatric** (e.g. transitioning to primary/secondary/university and/or adult services). • **Pregnancy** (e.g. pre/post conception pregnancy planning).	• **Newly diagnosed, HbA1c less than 8% (64mmol/mol)** (e.g. T2DSCP). • **Commencement of medication with no risk of hypoglycaemic risk** (e.g. Metformin, DPP4 inhibitors and/or GLP1 injectables). • **Paediatric** (e.g. transitioning to primary/secondary/university and/or adult services). **Pregnancy** (e.g. pre/post conception pregnancy planning).	**Post-natal OGTT follow up.**

Additional Notes

Clinical assessment will determine the degree of risk and thus an acceptable time frame for referral response and service provision. Service provision can occur via telehealth and with other regional LHN diabetes services. Information on private providers is to be offered where applicable.

- **Current or recent admission or recent SAAS call out without transfer to hospital** - any client requiring services related to a hospital admission or a SAAS call out are considered high risk and require early assessment via the Diabetes Rapid Access Service.
- **Diabetes ketoacidosis (DKA)** - is a medical emergency in type 1 diabetes but can also occur in type 2 diabetes where there is a significant deficit in insulin. Euglycaemia ketoacidosis is associated with the use of SGLT2 inhibitors in type 2 diabetes. Immediate medical assessment is required for prompt diagnosis and intensive management locally and/or up transfer.
- **Hyperglycaemic hyperosmolar State (HHS)** - is a medical emergency in type 2 diabetes. Immediate medical assessment is required for prompt diagnosis and intensive management locally and/or up transfer.
- **Insulin** - any client requiring services associated with insulin commencement and/or stabilisation are considered high risk and require early initial assessment. Clients considered stable can be prioritised based on clinical need.
- **Paediatric** - any child or adolescent with diabetes is considered a category 1 until further assessment. Paediatric diabetes is high risk and requires early initial assessment by a suitably qualified health professional.
- **Pregnancy** - any referral that indicates a combination of diabetes and pregnancy is considered a category 1 until further assessment. Diabetes in pregnancy is high risk and requires an early assessment by a suitably qualified health professional.
- **Aged care and residential care (outside of SA Health services)** - Admission assessment and annual reviews are considered category 4 and 5. Clinical need and risk may warrant a higher priority and response.
- **Diabetes reviews**
    - **Type 2 diabetes (adult)** - consider the Type 2 Diabetes Self Care Program (T2DSCP) for newly diagnosed and pre-existing type 2 diabetes referrals. Reviews are based on the above criteria, and not on a timeframe (e.g. yearly routine reviews or GP management plan or team care arrangement).
    - **Type 2 diabetes (paediatric)** - exceptions are made for children and young people with type 2 diabetes. Reviews will be triggered via the medical practitioners' diabetes cycle of care and referrals based on the above criteria.
    - **Type 1 diabetes (adult or paediatric)** is a significantly more complex health condition with greater risks; annual or bi-annual reviews are part of evidence-based care and will continue based on clinical need.
    - **Insulin pump therapy** only administers rapid acting insulin. In the event of insulin pump failure and/or the patient's inability to use the pump, diabetic ketoacidosis can develop within 3-4 hours. Advice must be sought and alternative insulin delivery (e.g. basal bolus insulin) is required.
    - **Continuous blood glucose monitoring (CGM) and flash glucose monitoring (FGM)** - clinical priority for review is based on the clinical need as outlined above.

For more information

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