User Guide to National Subcutaneous Insulin Form

(NSW Health Version)

For use in adult patients

November 2012
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User Guide to *National Subcutaneous Insulin Form*

**Exceptions:** This form is NOT intended to be used for children

### 1. Purpose

The purpose of this user guide is to explain how clinicians should use the *National Subcutaneous Insulin Form* to take full advantage of its safety features.

The safety features of the form promote consistent documentation to assist with accurate interpretation of subcutaneous insulin orders. The form is intended to reflect best practice. The specific sections of the form assist clinicians to safely prescribe and administer insulin, and to monitor blood glucose levels (BGLs). The Institute for Safe Medication Practices (ISMP) considers insulin a high risk medication.

Standardising the communication of medication information between doctors, nurses and pharmacists working in hospitals aims to reduce harm to patients from medication errors. This has been proven by the introduction of the National Inpatient Medication Chart (NIMC). Standardisation, in addition to reducing patient harm, allows for a collaborative approach to the training of medical, nursing and pharmacy staff in the use of a common form. Linking all the information required to manage inpatient diabetes requirements is expected to enable clinical staff to more effectively manage patient treatment. For patients who are not treated with insulin, the form is used for BGL monitoring.

The following are general requirements regarding use of the *Insulin Subcutaneous Order and Blood Glucose Record: Adult*.

- All authorised prescribers must order medicines for inpatients in accordance with legislative requirements according to the relevant state and territory drugs and poisons legislation.
- Orders should be reviewed daily and when notifications of out-of-range BGLs occur ensuring appropriate diabetes management and dosing of insulin.
- The form is to be utilised for all inpatients requiring subcutaneous insulin and/or BGL monitoring unless ward/unit procedures state otherwise.
- A different insulin chart is required for the prescribing, administration and monitoring of intravenous insulin.

### 2. General instructions

- All entries are to be written legibly in ink. No matter how accurate or complete an order, it may be misinterpreted if it cannot be read clearly.
- Water soluble ink (e.g. fountain pen) should not be used.
- Black ink is preferred.
- A medication order is valid only if the authorised prescriber enters all the required items.
- All information should be printed.
- No erasers or “whiteout” should be used.
- The form allows orders to be updated daily for 5 days, after which time the order must be rewritten on a new form. The patient’s current hospital and ward location should be clearly marked on the *Insulin Subcutaneous Order and Blood Glucose Record – Adult*: See Section 3.2.
3. Identification and demographics

3.1 Patient identification

Patient identification (ID) on the National Subcutaneous Insulin Form is consistent with the identification required when using the National Inpatient Medication Chart (NIMC).

A watermark has been included in the patient identification sections on pages 1 and 2 as a reminder that a prescription is not valid unless the patient’s identifiers are present. This can be done in one of 2 ways:

1. The current patient ID label placed on pages 1 and 2
2. As a minimum, written in legible print, the patient:
   - UR number
   - Name (family and given)
   - Address
   - Date of birth
   - Gender (M = Male; F = Female; I = Indeterminate)

The first prescriber must print the patient’s name under the label to verify that both the ID label and the insulin orders relate to the correct patient. This will reduce the risk of the wrong ID label being placed on the form which could lead to the wrong patient receiving insulin.

Insulin should not be administered if the prescriber has not completed the patient identification details. In these situations:
   - Contact the prescriber urgently as insulin should not be withheld.
   - If the original prescriber is not available, contact the doctor on-call.

3.2 Hospital demographics

Complete facility, ward / unit and year in this section (at the top right side of page 3).

3.3 Cross reference with National Inpatient Medication Chart (NIMC)

Tick the BGL/Insulin box on page 1 of the NIMC.
Cross reference the insulin order in the NIMC regular medications section to ensure insulin is not omitted during hospital admission and from discharge medications. Cross referencing should be done either by:

a) Placing a pre-printed sticker stating that ‘Insulin is Ordered for this Patient – See Insulin / BGL form’

![Insulin sticker](image)

OR

b) The authorised prescriber, pharmacist or registered nurse (RN) hand-writing on the section if stickers are unavailable.

![Handwritten note](image)

### 4. Monitoring / notification instructions

#### 4.1 BGL Frequency

The prescriber should indicate the BGL Frequency required for the patient in the Monitoring/Notifications Instructions section located at the top left of the form. Default BGL monitoring for an inpatient is pre-meals and at 21:00 hours. Tick all options that apply. More than one box can be ticked. Consider if patient requires more frequent BGL monitoring e.g. at 0200 hours if risk of nocturnal hypoglycaemia or fasting, and 2 hours post-meal if pregnant.

If the prescriber does not indicate the BGL frequency, BGLs should be recorded according to the Standard monitoring frequency (pre-meals and at 21:00 hrs).

![BGL Frequency selection box](image)

The BGL frequency should be reviewed and updated regularly in the appropriate date columns of the Monitoring Record.

![Monitoring Record example](image)
4.2 Medical Officer to notify / special Instructions

The prescriber should document who to notify of any BGL that is out of range or other concerns regarding diabetes management. If the name space (on the left side of page 2) is left blank, the resident medical officer for the treating team will be notified. The doctor on-call will be notified after hours.

Clinicians may document any Special Instructions related to the patient’s diabetes management in the space provided (on the left side of page 2).

4.3 Diabetes treatment prior to admission

Clinicians should write the Diabetes treatment prior to admission in the space provided (in the bottom right hand corner of page 3). This may include oral hypoglycaemic agents and/or insulin names and doses. Optional additional information may include the insulin device that the patient uses.

5. Monitoring record (for blood glucose levels)

5.1 Blood glucose monitoring

Generally, the BGL target range for most inpatients on general wards receiving subcutaneous insulin and/or oral treatments is 4-10mmol/L with up to 12mmol/L considered reasonable. In the Monitoring Record there are two rows that do not have any shading (4 -8mmol/L and 8.1 – 12mmol/L). If BGLs fall within this monitoring range, a doctor is not required to be notified unless requested in the Special Instructions area or if there are specific concerns. Certain situations (e.g. pregnancy) require tighter control. The Special Instructions area can be used to define specific BGL targets and notifications.

A doctor must be notified when:

- BGL is less than 4 mmol/L
- BGL is greater than 20 mmol/L
- two consecutive BGL results are greater than 16 mmol/L
- three consecutive BGL results are greater than 12 mmol/L.

To document a BGL:

- Document the date on the top of the current Date column.
- Document the Diet the patient is to receive for the day (e.g. Nil By Mouth (NBM), Total Parenteral Nutrition (TPN), clear fluids, full diet). This prompts re-assessment of insulin requirements should the patient be fasting for a procedure or have altered dietary requirements.
- Document the time the BGL is measured in the Time space at the top of the BGL column.
Perform a BGL according to facility procedure.

Write the BGL in the coloured row corresponding with the relevant range printed to the left and right of the Monitoring Record. Note any instructions in the ALERTS section that aligns with that range. See figure below.

If the BGL is less than 4mmol/L, initiate hypoglycaemia management as per Hypoglycaemia Management in Diabetes: BGL less than 4mmol/L which is printed on page 4 and notify the treating prescriber or doctor on-call. Then:

- Tick the Hypo Intervention box after initiating hypoglycaemia treatment and ensuring patient safety.
- Perform follow up BGLs according to Hypoglycaemia Management in Diabetes: BGL less than 4mmol/L which is printed on page 4 and respond accordingly (see section 10).
- Document the hypoglycaemia treatment and response in the medical record.

If the BGL is in a high alert range (i.e. greater than 20mmol/L or the second consecutive BGL greater than 16mmol/L or the third consecutive BGL greater than 12mmol/L):

- Notify the treating prescriber or doctor on-call
- Perform a urine or blood ketone test, document the result in the Ketones box and notify the prescriber of any positive result. Tick the Dr Notified box.
  - If a urine ketone test is performed, the result is documented as ‘neg’ if no ketones are present or as a ‘+’ or ‘+++’ etc. as indicated on the urine ketone test strip bottle.
  - If a blood ketone test is performed, the result is documented as a number (e.g. ‘0.6’ or ‘1.4’). Also document the actions taken in the medical record.

Further information can be documented in the Comments section below the Administration Record and in the medical record.
6. Insulin orders (prescribing)

Insulin orders are divided into three sections: Routine, Supplemental, and Stat / Phone Insulin Orders. Patients may require any combination of these orders.

If no insulin is prescribed for a patient with diabetes, this form should be used for BGL monitoring as the alerts and notification prompts also apply to patients not receiving insulin.

6.1 Routine insulin orders

There are six spaces to prescribe routine insulin in this section. Meal times are pre-printed to ensure insulin is given immediately before a patient eats. All mealtime insulin doses are to be given immediately before the patient eats, when their meal is in front of them. This includes those with a 15-30 minute delay in onset of action.

Rationale: In the hospital setting, meal delivery times are variable and if delayed after insulin has been administered, hypoglycaemia may result.

Prescribing spaces

There are four prescribing spaces with the following Meal / time pre-printed:

- Breakfast
- Lunch
- Dinner
- Pre-Bed

There are also two prescribing spaces without the pre-printed Meal / time; one at the top and one at the bottom of the Routine Insulin Orders section. The additional prescribing spaces are to be used when a patient has an additional insulin injection prescribed at a single meal / time. For example, if a patient receives both their basal insulin and their mealtime insulin at breakfast.

In the prescribing space for the appropriate meal / time (e.g. Breakfast) write the full trade/brand name of the insulin to be administered in the space marked Name of insulin. For premixed insulin specify the insulin type in full (e.g. ‘Mixtard 30/70’, ‘Humalog Mix 25’, ‘NovoMix 30’). ‘Mixtard’ or ‘Humalog Mix’ are not complete orders.

Rationale: Trade names are preferred for insulin prescribing to avoid confusion as there are many look-alike / sound-alike generic insulin names which are not interchangeable. Additionally, wherever possible the patient should receive the brand of insulin they use or will be using at home.

The prescriber must sign each order and initial in the grey shaded row immediately below the insulin and dose prescribing space (where initials is watermarked). The prescriber must print their name in full at least once per form.
At the top of the first Date column in the Routine Insulin Orders section, write the date the dose is to be administered. Write the number of units ordered as a whole number only in the box relevant to the meal / time the insulin is to be administered, under the appropriate date column.

‘Units’ is pre-printed as a watermark. Do not write ‘U’ or ‘IU’ as these abbreviations can cause serious dose administration errors (e.g. if 5u is misread as 50 units).

Example: Routine Insulin Orders

Each dose is prescribed in a different space according to the meal or time it is to be administered. If the patient has been receiving insulin and no dose is ordered for the next meal or time, the nurse must call the treating prescriber or the doctor on-call for a phone order. The previous day’s order is not a recurrent dose order.

In the event of a phone order being required, the nurse writes ‘phone’ in the appropriate insulin dose box of the Routine Insulin Orders section to indicate that a phone order has been taken. The dose ordered is documented in the Stat/Phone Insulin Orders section. See instructions at Section 6.3 Stat / Phone Insulin Orders.

Insulin doses must be ordered for each day. When writing up daily doses, it is appropriate to prescribe doses for the rest of that day and for the first dose(s) of the following day. The prescriber may order insulin doses for several days when the BGLs have been acceptable and stable in the range of 4-12mmol/L.

The prescriber orders the insulin doses for subsequent days in the additional Date columns. The new dose supersedes those written for previous dates. A new form must be written by the prescriber after 5 days, or when there is no space to order doses or record BGLs.

Immediately after prescribing insulin, the prescriber should write the full trade name of the insulin to be administered in the row/s in the Administration Record section with the prompt Name of routine insulin. Trade names are preferred in insulin prescribing to avoid confusion as discussed in Section 6.1.

Ceasing orders

To cease routine insulin orders the prescriber must draw a clear line through the order, taking care that the line does not obliterate the original order or other orders. The prescriber must write the reason for changing the order (e.g. cease, change to insulin regimen) and document the date the order was changed, then initial. Note: the acronym ‘D/C’ (discontinued) should not be used for ceased orders since this can be confused with ‘discharge’. Always use ‘cease’.

When the insulin regimen is being changed (not a dose change, which can be facilitated on the chart) the prescriber must not overwrite the order. The original order must be ceased and a new order written on a new subcutaneous insulin form.
6.2 Supplemental insulin orders

It is not necessary for all patients to have supplemental insulin prescribed. It might be considered where glycaemic control has been erratic and strict control is desirable. Supplemental insulin may be in addition to a routine mealtime or basal insulin dose. It may be required if the:

- Patient’s condition, dietary intake or a concurrent medication is altering their insulin requirements
- Patient has recently commenced subcutaneous insulin and optimal doses have not yet been determined.

Example: Prescription for supplemental doses to be administered with meals

Tick the Frequency the supplemental insulin dose is to be administered:

- With meals only if the patient is tolerating an oral diet
- 6 hourly if the patient is receiving continuous parenteral nutrition or tube feeding
- Other (specify) in specific circumstances and specify when it would be required.

Write the Name of Insulin to be administered in the space provided. Usually, if the patient is receiving rapid or short acting routine insulin with meals, the same type of insulin is prescribed as supplemental insulin.

Write the Start date and Start time that the orders are written.
Standardised BGL ranges, which are colour coded and match the BGL ranges in the Monitoring Record, are pre-printed on the form with a starting BGL range for supplemental insulin of 8.1-12mmol/L. If required, alternate BGL ranges may be used.

Document the insulin doses in the relevant Start date column. The doses should be written as a whole number, and be written against the BGL ranges at which they are to be administered. The word units is pre-printed as a watermark.

The prescriber must sign the order and print their name in the spaces provided. The prescriber must also write the full trade name of the supplemental insulin in the Administration Record row with the prompt Name of supplemental insulin.

The Supplemental Insulin Order remains valid until ceased or changed. This is in contrast to routine insulin orders, where doses are required for each day.

Rationale: Routine doses should be adjusted daily in response to the BGLs and the amount of supplemental insulin required in the previous 24 hours. The patient’s requirement for supplemental insulin should reduce as routine insulin doses are adjusted.

If necessary review and amend supplemental dose changes as required in the corresponding date columns. Changes are validated by the prescriber initialling at the bottom of the corresponding start date column.

The Supplemental Insulin Order does not continue past the last usable day on the form. After completion of a previous form, Supplemental Insulin Orders must be either:

- ordered on the new form if supplemental insulin is to be continued; or
- ceased on the expiring form to communicate the intention that the patient is no longer to receive supplemental insulin.

Administration of the insulin dose is documented in the Administration Record section (see section 6.4).

Ceasing supplemental orders

Draw a diagonal line through the order, document reason for change, sign and date.

Example: ceasing the supplemental order

Special Note:

Subcutaneous Sliding Scale insulin is NOT RECOMMENDED as sole insulin therapy. Basal insulin requirements should be considered.
6.3 Stat / phone insulin orders

Document any single stat or phone insulin dose orders in this section. Administration of the insulin dose is documented in the *Administration Record* section along with Routine doses (see section 7.3).

6.3.1 Stat orders

If the doctor is notified of an out-of-range BGL, a stat dose may be ordered. The prescriber must verbally inform the registered nurse responsible for the patient’s care of any stat orders.

6.3.2 Telephone orders

If a registered nurse takes a telephone phone order for any insulin dose (routine or due to an out-of-range BGL), they must document the order in the *Stat/Phone Insulin Orders* section. A second nurse must read back the written order to the prescriber to confirm that the order is correct and then countersign the phone order. The nurse(s) receiving the phone order must check if the stat / phone order replaces, or is in addition to, other insulin orders. If the order replaces a routine order she/he must write ‘phone’ in the in the appropriate dose box in the *Routine Insulin Orders* section.

Telephone orders should be signed by the prescriber within 24 hours or in accordance with State and Territory legislation.

![Stat/Phone Insulin Orders](image)

6.4 Administration record

When prescribing insulin, the prescriber should write the full trade name in the *Administration Record* where the rows prompt *Name of routine insulin* and *Name of supplemental insulin*. If the prescriber has not written the insulin trade name and the patient requires an insulin dose, the registered nurse or pharmacist may write the full trade name in these rows.

![Administration Record](image)
7. Documentation of insulin administration

See examples of documenting insulin administration throughout this section.

Administration of all insulin doses is documented in the Administration Record. Prepare and administer insulin according to facility procedure. Document the dose administered against the corresponding Name of routine insulin or Name of supplemental insulin row in the Administration Record. Document the time insulin is given. Initial in the Nurse 1 initials box to acknowledge administration of the dose. The second nurse checking the insulin dose should initial in the Nurse 2 initials box. The 2 sets of initials confirm the administration of each insulin dose.

A BGL should be performed within the 30 minutes before an insulin dose as it may change significantly prior to insulin administration if left longer. Insulin doses administered at mealtimes should be given immediately before a patient eats, when their meal is in front of them.

**Rationale:** In the hospital setting meal delivery times are variable and if delayed after insulin has been administered, hypoglycaemia may result.

*Routine, Supplemental* and *Stat / Phone* insulin orders may be ordered for the same time. If so, insulin orders that are the same type of insulin (e.g. short-acting) may be administered together but must be documented separately.

If clinical judgement indicates that a prescribed dose should not be administered (e.g. the patient is fasting or vomiting), notify the prescriber to review the dose. If for any reason an insulin dose cannot be administered as ordered notify the prescriber, enter code W for withheld and document in the clinical record. **Note:** It would be unusual for a patient with type one diabetes to have their insulin dose withheld completely.

7.1 Administration of a routine insulin dose

After taking and recording a BGL, check if an insulin dose is to be administered. Note: some patients may be prescribed more than one type of insulin at a time.

In the *Routine Insulin Orders* section Meal / times (i.e. Breakfast, Lunch, Dinner, Pre-Bed) are pre-printed. The dose is prescribed under the current Date column. If there is no dose ordered where one would be expected, contact the prescriber or doctor on-call to determine if a dose is required and to provide a phone order if it is.

Calculate and prepare total insulin dose (Routine +/- Supplemental +/- Stat / Phone).

Confirm the insulin type and dose is correct with another appropriately trained nurse. Check local procedure to determine whether different types of insulin can be mixed in the syringe.

Administer the insulin. Document the time insulin is given in the Time given row of the Administration Record to accurately reflect the time of administration (which may be slightly different from the time the BGL is recorded). Document the administration as outlined above. See example 7.5.1
7.2 Administration of a supplemental insulin dose

Review the Supplemental Insulin Orders and check whether supplemental insulin is required at that Meal / time according to the BGL ranges for which it is prescribed. Calculate and prepare the dose of insulin to be administered (and which may be in addition to a routine mealtime dose).

Administer the insulin and document the administration in the Administration Record as outlined above. See example 7.5.2. Supplemental insulin and routine insulin of the same type (e.g. short-acting) and due at the same time may be administered together but must be documented separately.

7.3 Documenting telephone orders and administration of phone orders

If a registered nurse takes a telephone order for any insulin dose (Routine or because BGL requires notification), the order is documented here. Note: A second nurse must read back the order documented by the first registered nurse to the doctor to confirm it is correct and then countersign the phone order. The nurse(s) receiving the telephone order must check to see if the Stat / Phone order replaces or is in addition to other insulin orders.

Document the administration of telephone order insulin in the Administration Record as outlined previously. Also cross reference the order by writing ‘phone’ in the dose box in the Routine Insulin Orders. See example 7.5.3.

The phone order must be signed by the authorised prescriber, or otherwise confirmed in writing according to facility procedure.

7.4 Documenting administration of stat orders

If the Medical Officer attends the ward and prescribes a single dose in the Stat / Phone Insulin Orders, then he/she must verbally inform the RN responsible for the patient’s care.

Prepare and administer the insulin and document the administration in the Administration Record as outlined above.
7.5 Examples
7.5.1 Routine insulin

The patient is prescribed 8 units of rapid acting insulin as a routine insulin dose for breakfast on 11/7/12. The BGL is 12mmol/L. Eight (8) units of insulin are ordered in the Routine Insulin Orders. There are no supplemental or stat / phone insulin orders, so the dose to be administered remains 8 units of routine rapid-acting insulin. The time of administration ‘0730’ is documented in the Time given row. 8 units of rapid-acting insulin is administered and documented as ‘8’: the total dose administered in the relevant row of the Administration Record. The nurses should initial to document the administration as outlined above.
7.5.2 Supplemental insulin

At lunchtime on 12/7/12, the patient is prescribed 8 units of rapid-acting insulin as a routine insulin dose. The BGL is 12.5mmol/L. By checking the Routine, Supplemental and Stat / Phone Insulin Orders sections, it can be seen that with a BGL of 12.5mmol/L the patient is to be administered 8 units of routine rapid-acting and 4 additional units of supplemental rapid-acting insulin. There is no stat / phone order.

The total insulin dose of 12 units of rapid acting mealtime insulin (8 units of routine rapid acting insulin plus 4 units of supplemental rapid acting insulin) is prepared and administered as a single injection. The time ‘12:45’ is documented in the Time given row. The 8 units of routine rapid acting insulin are documented in the Administration Record against the correct row with the prompt Name of routine insulin. The 4 units of supplemental rapid-acting insulin are documented in the Administration Record against the row with the Name of supplemental insulin prompt.

Prepared and administered as a single dose of 12 units but documented as Routine Insulin and Supplemental insulin doses.
7.5.3 Telephone orders

On the 14/7/12 there is no insulin ordered for lunchtime. As the patient has been receiving routine insulin, the nurse notifies the prescriber that the lunchtime BGL is 8mmol/L. A phone order is made for 9 units of rapid-acting insulin to Nurse 1 who initials to confirm receipt of the order. Nurse 2 reads the written phone order back to the prescriber to confirm and countersigns receipt of the order. Nurse 1 writes “phone” in the Routine Insulin Orders dose box to indicate that a phone order has been taken.

Nurse 1 and Nurse 2 then prepare the ordered insulin dose. Nurse 1 and Nurse 2 then administer the insulin and write the time as ‘12:45 in the Time given row. They write ‘9’ as the units administered and initial under the dose.

The prescriber signs the phone order within 24 hours or in accordance with state or territory legislation.

The nurse also cross references the phone order in the Routine Insulin Orders, so that clinicians are aware a phone order has been taken.
8. Comments section

This area (below the Administration Record) is for documenting communication between members of the team caring for the patient regarding insulin therapy and diabetes management.

Examples of what can be documented:

- the doctor has been notified of the BGL
- a hypoglycaemic event has been treated
- the patient has been changed to intravenous insulin.

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9. Guidelines for Managing Hyperglycaemia Alerts

The Guidelines for Managing Hyperglycaemic Alerts (on page 1) have been included to assist inexperienced and non-frequent prescribers and other clinicians. They are not designed to decrease autonomy or specialist input. If there are any clinical concerns, senior medical officer advice should be obtained.

The guidelines provide information related to:

1. assessment required when called for a Hyperglycaemia Alert
2. initiation of basal and mealtime insulin and adjustment of insulin doses
3. suggested stat and supplemental doses based on weight or previous total daily dose.
Guidelines for Managing Hyperglycaemia Alerts

1. Hydration and dietary status: is hyperglycaemia easily explained by dietary indiscretion?
2. Ketones: if ketone test is positive consider diabetic ketoacidosis (DKA), Seek expert advice
3. Concomitant medications: if on oral corticosteroids or Total Parenteral Nutrition (TPN) seek expert advice
4. Missed doses of insulin or oral hypoglycaemic agent
5. If not eating normally or markedly raised BG/Ls consider insulin infusion
6. Are alterations to insulin regimen or initiation of insulin required? Consider:
   a. Is it likely that insulin will be continued after discharge? If not, is it necessary to start it currently?
   b. What was the pre-morbid BG/L control like? What is current HbA1c?
   c. Does the patient want long term insulin treatment? If so, what is their preferred regimen?
   d. Was hyperglycaemia secondary to treated hypoglycaemia?

2. Previously taking routine insulin?
   Yes
   Currently on basal and mealtime insulin?
     Yes
     Hyperglycaemia within 4 hours of meal?
       Yes
       Consider: Increase basal dose by 20%
       OR: Increase that mealtime dose for the following day by 10%
     No
     Consider initiation of basal bolus insulin therapy
     Suggested starting doses:
     - Basal dose (units) = weight (kg) divided by 4
     - Mealtime (units) = weight (kg) divided by 12
   No
   Consider:
   - Conversion to basal bolus insulin:
   - Suggested starting doses are:
     - Basal (units) = total daily dose divided by 2
     - Mealtime (units) = total daily dose divided by 6
   - Adjust doses of current insulin regimen:
   - If adjusting current insulin regimen, increase corresponding dose the following day by 10%

3. Additional considerations:
   - Consider supplemental rapid / short-acting insulin (Table 1):
     - If previously on insulin, dose according to total daily dose
     - If not, dose according to weight
   - If insulin is started, ensure early referral (within 24 hours) to specialist diabetes nurse educator or equivalent service
   - Ongoing doses require daily review for adjustments according to BG/Ls and supplemental doses required over the previous days

Table 1: Suggested initial stat and supplemental rapid / short-acting insulin doses

<table>
<thead>
<tr>
<th>Previously on insulin: use previous total daily dose</th>
<th>Less than 26 units</th>
<th>26-50 units</th>
<th>51-100 units</th>
<th>More than 100 units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not previously on insulin: use actual weight</td>
<td>Less than 50 kg</td>
<td>50.1-100 kg</td>
<td>100.1-150 kg</td>
<td>More than 150 kg</td>
</tr>
<tr>
<td>BG/L mmol:</td>
<td>8.1-12</td>
<td>2 units</td>
<td>3 units</td>
<td>4 units</td>
</tr>
<tr>
<td></td>
<td>12.1-16</td>
<td>2 units</td>
<td>4 units</td>
<td>6 units</td>
</tr>
<tr>
<td></td>
<td>16.1-20</td>
<td>3 units</td>
<td>8 units</td>
<td>9 units</td>
</tr>
<tr>
<td></td>
<td>More than 20</td>
<td>4 units</td>
<td>8 units</td>
<td>12 units</td>
</tr>
</tbody>
</table>

Page 1 of 4
10. Hypoglycaemia Management in Diabetes: Adult

10.1 Hypoglycaemia Management in Diabetes: BGL Less than 4mmol/L

This flow diagram (on page 4) has been designed to standardise the management of hypoglycaemia in adults treated in the hospital setting (emergency department, inpatients and outpatients).

The flow diagram has four treatment pathway options based on the patient’s current condition, treatment and dietary status. These are determined by whether the patient is:

- conscious and cooperative
- receiving insulin via an intravenous insulin infusion
- nil by mouth or nil by tube
- receiving food orally or by tube.

Lists of appropriate food choices are supplied for use as initial and follow-up treatment according to the diet the patient is receiving.

- Food choices are determined from the standard options available at the site.
- Sites are encouraged to ensure that the chosen food choices are in a central location in each ward, unit and outpatient facility.
- Each ward, unit and outpatient facility should have access to intravenous glucose 50% and glucagon 1mg injection to use in emergency situations.
- Glucose based products are preferred as initial treatment.
- Diet (low kilojoule) products must not be used to treat hypoglycaemia.
Hypoglycaemia Management in Diabetes: BGL Less than 4mmol/L

If on insulin infusion, stop insulin infusion, continue glucose infusion AND Position patient on side and maintain airway AND Call a code blue / Medical Emergency AND Never give anything orally to a patient who is unconscious or drowsy

If IV access, R/N/doctor to administer OR administer OR administer 30mL 50% glucose as slow IV push

If the patient is not NBM: R/N/doctor to administer OR administer 1mg glucagon IM (1 dose only)

If the patient is not NBM: Give one serve fast acting carbohydrate from list below

Contact doctor urgently AND If IV access, R/N/doctor to administer OR administer 30mL 50% glucose as slow IV push

If no IV access, administer OR administer BGL greater than 4?

Commence or revise IV glucose infusion and review diabetes management

Recheck BGL after 15 mins

BGL greater than 4?

Yes

Doctor to revise insulin infusion rate and concurrent glucose infusion

Recommend insulin infusion and glucose infusion at adjusted rate 15 minutes after hypoglycaemic event has resolved

Recheck BGL after 15 mins

BGL greater than 4?

Yes

Stay with patient until they regain consciousness

If unconscious and BGL greater than 4, manage decreased level of consciousness

If patient conscious follow up with appropriate oral or IV treatment

No

BGL greater than 4?

Yes

Give 1 serve of fast acting carbohydrate from list below

If IV access, R/N/doctor to administer OR administer OR administer 30mL 50% glucose as slow IV push

If no IV access, administer OR administer

Commence or revise IV glucose infusion and review diabetes management

Recheck BGL after 15 mins

BGL greater than 4?

Yes

Follow up: 1 serve of slow acting carbohydrate from list below

• Repeat BGL after 1 hour.
• Document hypoglycaemic event on BGL and insulin chart and document actions taken in patient record.
• Notify doctor to review recent diabetes treatment.
• Beware of recurrent hypoglycaemia, risk is greater with oral agents. Doctor must review.
• Always give follow up oral carbohydrates or IV glucose after glucagon injection.

**Fast Acting Carbohydrate** (give one serve (15 grams) of one of the following as initial treatment)

<table>
<thead>
<tr>
<th>Normal Diet</th>
<th>Thickened Diet (full thick)</th>
<th>PEG or Nasogastric Feed (via feeding tube)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100mL Loozacote™</td>
<td>1 tub preg prepared thickened cordial (not diet)</td>
<td>100mL Loozacote™</td>
</tr>
<tr>
<td>1 serve Polyjuice™ as per directions</td>
<td>3 individual servers of jam (not diet)</td>
<td>1 serve Polyjuice™ as per directions</td>
</tr>
<tr>
<td>150mL lemonade or other softdrink (not diet)</td>
<td>38mL cordial (not diet) mixed with 150mL water</td>
<td>150mL orange juice</td>
</tr>
<tr>
<td>10 Glucodote™ tablets</td>
<td></td>
<td>38mL cordial (not diet) mixed with 150mL water</td>
</tr>
<tr>
<td>3 teaspoons/sachets sugar dissolved in 50mL water</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 small or 4 large glucose jellybeans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>150mL orange juice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38mL cordial (not diet) mixed with 150mL water</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Slow Acting Carbohydrate** (give one serve (15 grams) of one of the following as follow up treatment)

<table>
<thead>
<tr>
<th>Normal</th>
<th>Thickened Diet (full thick)</th>
<th>PEG or Nasogastric Feed (via feeding tube)</th>
</tr>
</thead>
<tbody>
<tr>
<td>250mL milk</td>
<td>1 tub pureed fruit</td>
<td>150mL enteral feed</td>
</tr>
<tr>
<td>1 tub (200g) yoghurt</td>
<td>1 serve thickened milk drink</td>
<td></td>
</tr>
<tr>
<td>1 slice bread</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 sweet plain biscuits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 piece fruit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Next meal (if being served within 30 mins)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
10.2 Diabetes treatment review following treated hypoglycaemia

Diabetes management must be reviewed in response to a hypoglycaemic event and clinicians should refer to the *Diabetes treatment review following treated hypoglycaemia* guidelines.

<table>
<thead>
<tr>
<th>Diabetes treatment review following treated hypoglycaemia</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assess patient – provide basic and advanced life support if required.</td>
</tr>
<tr>
<td>2. Review diabetes management for causes of hypoglycaemia and correct avoidable causes:</td>
</tr>
<tr>
<td>a. If the cause is identified and corrected (e.g. missed, delayed or reduced intake), insulin dose adjustment is not required unless hypoglycaemia recurs.</td>
</tr>
<tr>
<td>b. If the cause is not identified or cannot be corrected and:</td>
</tr>
<tr>
<td>i. hypoglycaemia has occurred <em>within</em> 4 hours after mealtime insulin, reduce the dose of that mealtime insulin by 20% the following day.</td>
</tr>
<tr>
<td>ii. If hypoglycaemia has occurred <em>outside</em> 4 hours after mealtime insulin reduce basal insulin dose by 20%.</td>
</tr>
<tr>
<td>3. If on insulin and eating normally, do not withhold subsequent mealtime or basal insulin after treating hypoglycaemia.</td>
</tr>
<tr>
<td>a. If reduced oral intake consider reducing mealtime insulin dose(s).</td>
</tr>
<tr>
<td>4. If on a sulphonylurea, obtain specialist advice on management as hypoglycaemia can be recurrent or prolonged:</td>
</tr>
<tr>
<td>a. Monitor BGL hourly for 4 hours, then 4 hourly for 24 hours after last hypoglycaemic episode.</td>
</tr>
<tr>
<td>b. If recurrent hypoglycaemia, commence IV glucose titrating rate to BGL greater than 4 mmol/L.</td>
</tr>
<tr>
<td>c. Withhold oral hypoglycaemic treatment until recovered and review whether further therapy is required.</td>
</tr>
</tbody>
</table>

11. Pharmacy review

It has been clearly demonstrated that inpatients benefit from a clinical pharmacist review of their medication regimen. Associated activities such as liaison with medical and nursing staff, clarification of orders, supply and administration information are necessary to ensure safe and effective outcomes for patients.

The clinician undertaking pharmacy review should sign the *Pharmacy Review* section (on the bottom right side of page 3) as a record that they have reviewed the insulin form (on the corresponding day) to ensure that all insulin orders are clear, safe and appropriate for that individual patient, therefore reducing the risk of an adverse drug event.

<table>
<thead>
<tr>
<th>Pharmacy Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date: 11/7</td>
</tr>
<tr>
<td>IC</td>
</tr>
<tr>
<td>Inits</td>
</tr>
</tbody>
</table>