Location: _____

General

Discontinue Insulin Infusion

☑ **Discontinue Insulin infusion** Once, 1, Occurrences, Routine, If on an insulin infusion: * immediately administer long-acting subcutaneous insulin as ordered (intentional overlap with IV insulin infusion) * continue the IV insulin infusion and hourly glucose checks for 2 hours after the long-acting subcutaneous insulin was administered, then discontinue the IV insulin infusion * if transitioning off of the DKA insulin protocol, please also continue the two-bag IV fluids until the IV insulin infusion is turned off (2 hours after the subcutaneous insulin was administered)

Finger Stick Blood Glucose (FSBG) Monitoring (MUST choose one) (Required)

○ **Bedside glucose - for patients on diets** 4 times daily 0-30 minutes before meals and at bedtime, Routine, Blood, 0-30 mins before meals and at bedtime (if on diet). Give correction insulin BEFORE MEALS ONLY, if needed.

○ **Bedside glucose - for patients on continuous enteral feeds, TPN or NPO** Every 4 hours, Routine, Blood, Give correction insulin EVERY 4 HOURS, if needed.

Finger Stick Blood Glucose (FSBG) Monitoring - Additional 1 AM

For patients transitioning from insulin infusion to subcutaneous insulin regimen in the first 24 hours

○ **Bedside glucose - for patients transitioning from insulin infusion** Once, 1, Occurrences, 0100, Routine, Blood, This additional bedside glucose is for transition from insulin infusion to subcutaneous insulin regimen. DO NOT TREAT WITH INSULIN. Notify ordering Provider if Blood Glucose below 70 mg/dL or greater than 300 mg/dL.

Subcutaneous Insulin Dosing (choose all that apply)

Click here to view Insulin Dosing Guidelines:

Insulin Dosing Guidelines (\\epic-nas.et0922.epichosted.com\static\OrderSets\RX999 Attachment A Diabetes Management dosing card Revision 2 2-2015 FontREV.pdf)

Basal Insulin

☐ **Insulin glargine (Lantus)**

☐ **insulin glargine (LANTUS) injection** 100 , subcutaneous, daily
DO NOT HOLD glargine without a prescriber order. If glucose is less than 80mg/dL, call prescriber for possible dose change.

☐ **insulin glargine (LANTUS) injection** 100 , subcutaneous, nightly
DO NOT HOLD glargine without a prescriber order. If glucose is less than 80mg/dL, call prescriber for possible dose change.

☐ **insulin glargine (LANTUS) injection** 100 , subcutaneous, 2 times daily
DO NOT HOLD glargine without a prescriber order. If glucose is less than 80mg/dL, call prescriber for possible dose change.

☐ **Weight based: Insulin glargine (Lantus)**

☐ **For insulin SENSITIVE patients (0.1 units/kg/day)** 0.1 Units/kg/day, subcutaneous
DO NOT HOLD glargine without a prescriber order. If glucose is less than 80 mg/dL, call prescriber for possible dose change.

☐ **For AVERAGE patients (0.2 units/kg/day)** 0.2 Units/kg/day, subcutaneous
DO NOT HOLD glargine without a prescriber order. If glucose is less than 80 mg/dL, call prescriber for possible dose change.

☐ **For insulin RESISTANT patients (0.3 units/kg/day)** 0.3 Units/kg/day, subcutaneous
DO NOT HOLD glargine without a prescriber order. If glucose is less than 80 mg/dL, call prescriber for possible dose change.

☐ **Insulin NPH (HumuLIN-N)**

☐ **insulin NPH (HumuLIN-N)** 100 , subcutaneous, 2 times daily
If NPO give half dose of scheduled NPH or NPH/REG

☐ **insulin NPH (HumuLIN-N)** 100 , subcutaneous, daily with breakfast
If NPO give half dose of scheduled NPH or NPH/REG

☐ **insulin NPH (HumuLIN-N)** 100 , subcutaneous, nightly
If NPO give half dose of scheduled NPH or NPH/REG

☐ **Insulin 70/30 NPH and Regular Human (HumuLIN 70/30)**

☐ **insulin NPH/REG (HumuLIN 70/30)** 100 , subcutaneous, 2 times daily with meals
If NPO give half dose of scheduled NPH/REG

☐ **insulin NPH/REG (HUMULIN 70/30)** 100 , subcutaneous, daily with breakfast
If NPO give half dose of scheduled NPH/REG

☐ **insulin NPH/REG (HUMULIN 70/30)** 100 , subcutaneous, daily with dinner
If NPO give half dose of scheduled NPH/REG

Mealtime Insulin

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

○ **Custom Mealtime Insulin lispro (HumaLOG)**

☐ **Three times daily with meals - insulin lispro (AdmeLOG)** 100 , subcutaneous, 3 times daily with meals
If NPO or pre-meal glucose is less than 80 mg/dL, hold the dose of mealtime insulin. If pre-meal glucose is 80 - 100 mg/dL, give ½ dose of mealtime insulin. May be given up to 10 minutes before meal or immediately after meal if oral intake is uncertain. If corrective insulin dose is needed, add to mealtime insulin dose.

1 unit for every __ gm of CHOs and 1 unit for every ___ mg/dL of glucose GREATER than ___ mg/dL. Patient will estimate the amount of carbohydrates consumed. Nursing staff will calculate and administer the appropriate insulin dose based on the prescribed insulin-to-carbohydrate ratio and correction factor.

☐ **Before Breakfast - insulin lispro (AdmeLOG)** 100 , subcutaneous, daily with breakfast
If NPO or pre-meal glucose is less than 80 mg/dL, hold the dose of mealtime insulin. If pre-meal glucose is 80 - 100 mg/dL, give ½ dose of mealtime insulin. May be given up to 10 minutes before meal or immediately after meal if oral intake is uncertain. If corrective insulin dose is needed, add to mealtime insulin dose.

☐ **Before Lunch - insulin lispro (AdmeLOG)** 100 , subcutaneous, daily before lunch
If NPO or pre-meal glucose is less than 80 mg/dL, hold the dose of mealtime insulin. If pre-meal glucose is 80 - 100 mg/dL, give ½ dose of mealtime insulin. May be given up to 10 minutes before meal or immediately after meal if oral intake is uncertain. If corrective insulin dose is needed, add to mealtime insulin dose.

☐ **Before Dinner - insulin lispro (AdmeLOG)** 100 , subcutaneous, daily before dinner
If NPO or pre-meal glucose is less than 80 mg/dL, hold the dose of mealtime insulin. If pre-meal glucose is 80 - 100 mg/dL, give ½ dose of mealtime insulin. May be given up to 10 minutes before meal or immediately after meal if oral intake is uncertain. If corrective insulin dose is needed, add to mealtime insulin dose.

☐ **With Snacks - insulin lispro (AdmeLOG) injection** 100 , subcutaneous, with snacks
If NPO or pre-meal glucose is less than 80 mg/dL, hold the dose of mealtime insulin. If pre-meal glucose is 80 - 100 mg/dL, give ½ dose of mealtime insulin. May be given up to 10 minutes before meal or immediately after meal if oral intake is uncertain. If corrective insulin dose is needed, add to mealtime insulin dose.

○ **Weight Based Insulin Lispro (HumaLOG)**

○ **For insulin SENSITIVE patients (0.1 units/kg/day)** 0.1 Units/kg/day, subcutaneous, 3 times daily with meals
: If NPO or pre-meal glucose is less than 80mg/dL, HOLD the dose of mealtime insulin. If pre-meal glucose is 80-100 mg/dL, give 1/2 dose of mealtime insulin. May be given up to 10 minutes before a meal or immediately after meal if oral intake is uncertain. If corrective insulin dose is needed, add to mealtime insulin dose.

○ **For AVERAGE patients (0.2 units/kg/day)** 0.2 Units/kg/day, subcutaneous, 3 times daily with meals
: If NPO or pre-meal glucose is less than 80mg/dL, HOLD the dose of mealtime insulin. If pre-meal glucose is 80-100 mg/dL, give 1/2 dose of mealtime insulin. May be given up to 10 minutes before a meal or immediately after meal if oral intake is uncertain. If corrective insulin dose is needed, add to mealtime insulin dose.

○ **For insulin RESISTANT patients (0.3 units/kg/day)** 0.3 Units/kg/day, subcutaneous, 3 times daily with meals
: If NPO or pre-meal glucose is less than 80mg/dL, HOLD the dose of mealtime insulin. If pre-meal glucose is 80-100 mg/dL, give 1/2 dose of mealtime insulin. May be given up to 10 minutes before a meal or immediately after meal if oral intake is uncertain. If corrective insulin dose is needed, add to mealtime insulin dose.

Tube Feed or TPN

☐ **For patients on Tube Feeds or TPN - Insulin NPH and Dextrose 10%**

☑ **insulin NPH (HumuLIN-N) injection** 100 , subcutaneous, every 8 hours scheduled
TPN - If TPN stopped for 30 minutes or greater, HOLD scheduled insulin and start D10W at the previous TPN rate up to a maximum rate of 40 mL/hr.
Tube feeds - If patient on scheduled insulin and tube feeds stopped for 30 minutes or greater, HOLD scheduled insulin and start D10W at the previous tube feed rate up to a maximum rate of 40 mL/hr.
Check blood glucose (BG) every 4 hours. Stop D10 if BG 200 or above and notify prescriber for further orders. If TPN or tube feeds resumed, stop D10.

☑ **dextrose 10 % infusion** 40 mL/hr, intravenous, continuous PRN, for interruption in TPN or tube feeds, other
TPN - If TPN stopped for 30 minutes or greater, HOLD scheduled insulin and start D10W at the previous TPN rate up to a maximum rate of 40 mL/hr.
Tube feeds - If patient on scheduled insulin and tube feeds stopped for 30 minutes or greater, HOLD scheduled insulin and start D10W at the previous tube feed rate up to a maximum rate of 40 mL/hr.
Check blood glucose (BG) every 4 hours. Stop D10 if BG 200 or above and notify prescriber for further orders. If TPN or tube feeds resumed, stop D10.

Corrective Insulin

☐ **Insulin Lispro (HUMALOG, ADMELOG) Corrective Insulin**

○ **Patient UNABLE to tolerate LISPRO** Once, Routine

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

○ **Low Dose Corrective Scale** 100
Corrective Scale: ○ LOW dose correction scale
For hypoglycemic episodes, follow hypoglycemia management algorithm.
Do Not Administer if Patient is Receiving Insulin Infusion. Physicians/APPs only: Use the Modify button on the Orders tab to change the corrective scale.

○ **Medium Dose Corrective Scale** 100
Corrective Scale: ○ MEDIUM dose correction scale
For hypoglycemic episodes, follow hypoglycemia management algorithm.
Do Not Administer if Patient is Receiving Insulin Infusion. Physicians/APPs only: Use the Modify button on the Orders tab to change the corrective scale.

○ **High Dose Corrective Scale** 100
Corrective Scale: ○ HIGH dose correction scale
For hypoglycemic episodes, follow hypoglycemia management algorithm.
Do Not Administer if Patient is Receiving Insulin Infusion. Physicians/APPs only: Use the Modify button on the Orders tab to change the corrective scale.

○ **Corrective Insulin**

☐ **insulin lispro (ADMELOG) injection** 100 , subcutaneous
Define custom scale here ***
10 minutes before meal or immediately after meal.

☐ **Bedtime Correction Scale 0-4 units – only for persistent hyperglycemia (>250mg/dL)**
Bedside Glucose: "0200 bedside glucose (POC) is required to prevent nocturnal hypoglycemia for patient safety."

☑ **insulin lispro (ADMELOG) injection** 0 - 4 Units, subcutaneous, at bedtime
Corrective Scale: ○ BEDTIME dose correction scale
Obtain bedside glucose (POC) at 0200

41 - 69 mg/dL blood glucose: give 25 mL of dextrose 50% OR 4 ounce juice
0 - 40 mg/dL blood glucose: give 50 mL of dextrose 50%

Consider HS snack if poor PO intake.

Do Not Administer if Patient is Receiving Insulin Infusion.

☑ **Bedside glucose** Daily at 0200, Routine, Blood, Obtain bedside glucose (POC) at 0200.

Hypoglycemia Management
Hypoglycemia Management

◉ **Hypoglycemia Management for Adult Patients** (Required)

☑ **Hypoglycemia management - Monitor patient for signs and symptoms of HYPOglycemia and follow standing delegation orders** Per unit protocol, Routine, CLICK REFERENCE LINK TO OPEN ALGORITHM:

☑ **dextrose 50% intravenous syringe** 12.5 g, intravenous, every 20 min PRN, If blood glucose is between 41-69 mg/dL, low blood glucose
For blood glucose between 41-69 mg/dL, give ½ cup juice if patient is able or dextrose 50% intravenous solution 12.5 g (25mL) IV push ONCE.
Contact the provider and recheck blood glucose in 20 minutes until glucose is greater than 100 mg/dL.
DO NOT give further insulin until ordered by a provider

☑ **dextrose 50% intravenous syringe** 25 g, intravenous, every 20 min PRN, if blood glucose is less than or equal 40 mg/dL, low blood glucose
Recheck bedside glucose every 20 min until glucose greater than 100 mg/dL.

☑ **glucagon injection** 1 mg, intramuscular, every 15 min PRN, if patient NPO, unable to swallow safely with no IV access., low blood glucose
If glucose remains LESS than 70 mg/dL, after 2 doses of D50 or Glucagon, send serum glucose level STAT.
Initiate treatment immediately after lab drawn.
Do NOT delay treatment waiting for lab result.
Recheck blood sugar every 20 min until greater than 100 mg/dL.
Notify Provider.

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☑ **dextrose 10 % infusion** 40 mL/hr, intravenous, continuous PRN, For bedside glucose LESS than 70 mg/dL
For use after administration of dextrose 50% x 2 and subsequent glucose value LESS than 70 mg/dL.
Notify Provider, consider transfer to ICU. Check Glucose every hour while on D10 infusion. Titrate infusion by 10 mL per hour to keep glucose between 100 and 140 mg/dL.
Notify provider when ANY/ALL of the following occur:
-Dextrose 10% infusion is started
-If glucose is less than 70 mg/dL while on dextrose 10% infusion
-When dextrose 10% infusion rate is increased to greater than 100 mL/hr

Labs

Laboratory

☐ **Hemoglobin A1c** Once, Routine, Blood, 3

☐ **Lipid panel** Once, Routine, Blood, 3

Consults

Consults HMH

☐ **Consult Diabetes/Endocrinology** Once, Routine, Please call Inpatient Diabetes/Hyperglycemia Management Service 713-441-0006
Reason for Consult? ○ Diabetes and Hyperglycemia
Patient/Clinical information communicated?
Patient/clinical information communicated?
To Provider:
Provider Group:

☐ **Consult Diabetes Education** Once, Routine
Reason for Consult:
Reason for Consult?
Note: Do NOT hold discharge for diabetes education

☐ **Consult Nutrition Services** Once, Routine
Reason For Consult?
Purpose/Topic:
Reason for Consult?

☐ **Ambulatory referral to HM Weight Management Center** Once

Consults HMTW

☐ **Consult Nutrition Services** Once, Routine
Reason For Consult?
Purpose/Topic:
Reason for Consult?

☐ **Consult to Diabetes Education** Once, Routine
Reason for Consult:
Reason for Consult?
Note: Do NOT hold discharge for diabetes education

☐ **Ambulatory referral to HM Weight Management Center** Once

Consults - NOT HMH or HMTW

☐ **Consult Diabetes Education** Once, Routine
Reason for Consult:
Reason for Consult?
Note: Do NOT hold discharge for diabetes education

☐ **Consult Nutrition Services** Once, Routine
Reason For Consult?
Purpose/Topic:
Reason for Consult?

☐ **Ambulatory referral to HM Weight Management Center** Once

Sign:_____ **Printed Name:**_____ **Date/Time:**_____