Location: _____

General

Discontinue Insulin Infusion

☑ **Discontinue Insulin infusion** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine **Comments:** 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** **Frequency:** 4 times daily 0-30 minutes before meals and at bedtime **Priority:** Routine **Specimen Type:** Blood **Comments:** 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** **Frequency:** Every 4 hours **Priority:** Routine **Specimen Type:** Blood **Comments:** 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** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Start Time:** 0100 **Priority:** Routine **Specimen Type:** Blood **Comments:** 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** **Dose:** 100 **Route:** subcutaneous **Frequency:** daily
Admin Instructions:
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** **Dose:** 100 **Route:** subcutaneous **Frequency:** nightly
Admin Instructions:
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** **Dose:** 100 **Route:** subcutaneous **Frequency:** 2 times daily
Admin Instructions:
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)** **Dose:** 0.1 Units/kg/day **Route:** subcutaneous
Admin Instructions:
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)** **Dose:** 0.2 Units/kg/day **Route:** subcutaneous
Admin Instructions:
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)** **Dose:** 0.3 Units/kg/day **Route:** subcutaneous
Admin Instructions:
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)** **Dose:** 100 **Route:** subcutaneous **Frequency:** 2 times daily
Admin Instructions:
If NPO give half dose of scheduled NPH or NPH/REG

☐ **insulin NPH (HumuLIN-N)** **Dose:** 100 **Route:** subcutaneous **Frequency:** daily with breakfast
Admin Instructions:
If NPO give half dose of scheduled NPH or NPH/REG

☐ **insulin NPH (HumuLIN-N)** **Dose:** 100 **Route:** subcutaneous **Frequency:** nightly
Admin Instructions:
If NPO give half dose of scheduled NPH or NPH/REG

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

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

☐ **insulin NPH/REG (HumuLIN 70/30) Dose:** 100 **Route:** subcutaneous **Frequency:** 2 times daily with meals
Admin Instructions:
If NPO give half dose of scheduled NPH/REG

☐ **insulin NPH/REG (HUMULIN 70/30) Dose:** 100 **Route:** subcutaneous **Frequency:** daily with breakfast
Admin Instructions:
If NPO give half dose of scheduled NPH/REG

☐ **insulin NPH/REG (HUMULIN 70/30) Dose:** 100 **Route:** subcutaneous **Frequency:** daily with dinner
Admin Instructions:
If NPO give half dose of scheduled NPH/REG

Mealtime Insulin

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

☐ **Three times daily with meals - insulin lispro (AdmeLOG) Dose:** 100 **Route:** subcutaneous **Frequency:** 3 times daily with meals
Admin Instructions:
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) Dose:** 100 **Route:** subcutaneous **Frequency:** daily with breakfast
Admin Instructions:
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) Dose:** 100 **Route:** subcutaneous **Frequency:** daily before lunch
Admin Instructions:
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) Dose:** 100 **Route:** subcutaneous **Frequency:** daily before dinner
Admin Instructions:
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 Dose:** 100 **Route:** subcutaneous **Frequency:** with snacks
Admin Instructions:
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) Dose:** 0.1 Units/kg/day **Route:** subcutaneous **Frequency:** 3 times daily with meals
Admin Instructions:
: 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) Dose:** 0.2 Units/kg/day **Route:** subcutaneous **Frequency:** 3 times daily with meals
Admin Instructions:
: 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.

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

○ **For insulin RESISTANT patients (0.3 units/kg/day) Dose:** 0.3 Units/kg/day **Route:** subcutaneous **Frequency:** 3 times daily with meals
Admin Instructions:
: 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 Dose:** 100 **Route:** subcutaneous **Frequency:** every 8 hours scheduled
Admin Instructions:
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 Dose:** 40 mL/hr **Route:** intravenous **Frequency:** continuous PRN **PRN Comment:** for interruption in TPN or tube feeds **PRN Reasons:** other
Admin Instructions:
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 Frequency:** Once **Priority:** Routine

○ **Low Dose Corrective Scale Dose:** 100
Question(s):
Corrective Scale: ○ LOW dose correction scale
Admin Instructions:
For hypoglycemic episodes, follow hypoglycemia management algorithm.
Product Admin Instructions:
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 Dose:** 100
Question(s):
Corrective Scale: ○ MEDIUM dose correction scale
Admin Instructions:
For hypoglycemic episodes, follow hypoglycemia management algorithm.
Product Admin Instructions:
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 Dose:** 100
Question(s):
Corrective Scale: ○ HIGH dose correction scale
Admin Instructions:
For hypoglycemic episodes, follow hypoglycemia management algorithm.
Product Admin Instructions:
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 Dose:** 100 **Route:** subcutaneous
Admin Instructions:
Define custom scale here ***
Product Admin Instructions:
10 minutes before meal or immediately after meal.

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

☐ **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 Dose:** 0 - 4 Units **Route:** subcutaneous **Frequency:** at bedtime
Question(s):
Corrective Scale: ○ BEDTIME dose correction scale
Admin Instructions:
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.

Product Admin Instructions:
Do Not Administer if Patient is Receiving Insulin Infusion.

☑ **Bedside glucose Frequency:** Daily at 0200 **Priority:** Routine **Specimen Type:** Blood **Comments:** 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 Frequency:** Per unit protocol **Priority:** Routine **Comments:** CLICK REFERENCE LINK TO OPEN ALGORITHM:

☑ **dextrose 50% intravenous syringe Dose:** 12.5 g **Route:** intravenous **Frequency:** every 20 min PRN **PRN Comment:** If blood glucose is between 41-69 mg/dL **PRN Reasons:** low blood glucose
Admin Instructions:
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 Dose:** 25 g **Route:** intravenous **Frequency:** every 20 min PRN **PRN Comment:** if blood glucose is less than or equal 40 mg/dL **PRN Reasons:** low blood glucose
Admin Instructions:
Recheck bedside glucose every 20 min until glucose greater than 100 mg/dL.

☑ **glucagon injection Dose:** 1 mg **Route:** intramuscular **Frequency:** every 15 min PRN **PRN Comment:** if patient NPO, unable to swallow safely with no IV access. **PRN Reasons:** low blood glucose
Admin Instructions:
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.

☑ **dextrose 10 % infusion Dose:** 40 mL/hr **Route:** intravenous **Frequency:** continuous PRN **PRN Comment:** For bedside glucose LESS than 70 mg/dL
Admin Instructions:
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 Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Lipid panel Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

Consults

Consults HMH

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

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

☐ **Consult Diabetes Education** **Frequency:** Once **Priority:** Routine
Question(s):
Reason for Consult:
Reason for Consult?
Process Instructions:
Bedside Nurse Instruction:
Begin insulin teaching at the bedside-do not wait for the Diabetes Educator. Use teach-back and have the patient self-administer (as appropriate) to build early competence.

Prescribing Provider (APP/Physician) Instruction:
Discuss the discharge diabetes plan with the patient and provide initial instructions prior to placing the DE consult. Establishing this baseline understanding allows the Diabetes Educator to focus on insulin administration, skills practice, and teach-back competency

Note: Do NOT hold discharge for diabetes education

☐ **Consult Nutrition Services** **Frequency:** Once **Priority:** Routine
Question(s):
Reason For Consult?
Purpose/Topic:
Reason for Consult?

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

Consults HMTW

☐ **Consult Nutrition Services** **Frequency:** Once **Priority:** Routine
Question(s):
Reason For Consult?
Purpose/Topic:
Reason for Consult?

☐ **Consult to Diabetes Education** **Frequency:** Once **Priority:** Routine
Question(s):
Reason for Consult:
Reason for Consult?
Process Instructions:
Bedside Nurse Instruction:
Begin insulin teaching at the bedside-do not wait for the Diabetes Educator. Use teach-back and have the patient self-administer (as appropriate) to build early competence.

Prescribing Provider (APP/Physician) Instruction:
Discuss the discharge diabetes plan with the patient and provide initial instructions prior to placing the DE consult. Establishing this baseline understanding allows the Diabetes Educator to focus on insulin administration, skills practice, and teach-back competency

Note: Do NOT hold discharge for diabetes education

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

Consults - NOT HMH or HMTW

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

☐ **Consult Diabetes Education** **Frequency:** Once **Priority:** Routine
Question(s):
Reason for Consult:
Reason for Consult?
Process Instructions:
Bedside Nurse Instruction:
Begin insulin teaching at the bedside-do not wait for the Diabetes Educator. Use teach-back and have the patient self-administer (as appropriate) to build early competence.

Prescribing Provider (APP/Physician) Instruction:
Discuss the discharge diabetes plan with the patient and provide initial instructions prior to placing the DE consult. Establishing this baseline understanding allows the Diabetes Educator to focus on insulin administration, skills practice, and teach-back competency

Note: Do NOT hold discharge for diabetes education

☐ **Consult Nutrition Services** **Frequency:** Once **Priority:** Routine
Question(s):
Reason For Consult?
Purpose/Topic:
Reason for Consult?

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

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