

Attach Patient Sticker here or record

NAME:

NHS NO:

HOSP NO:

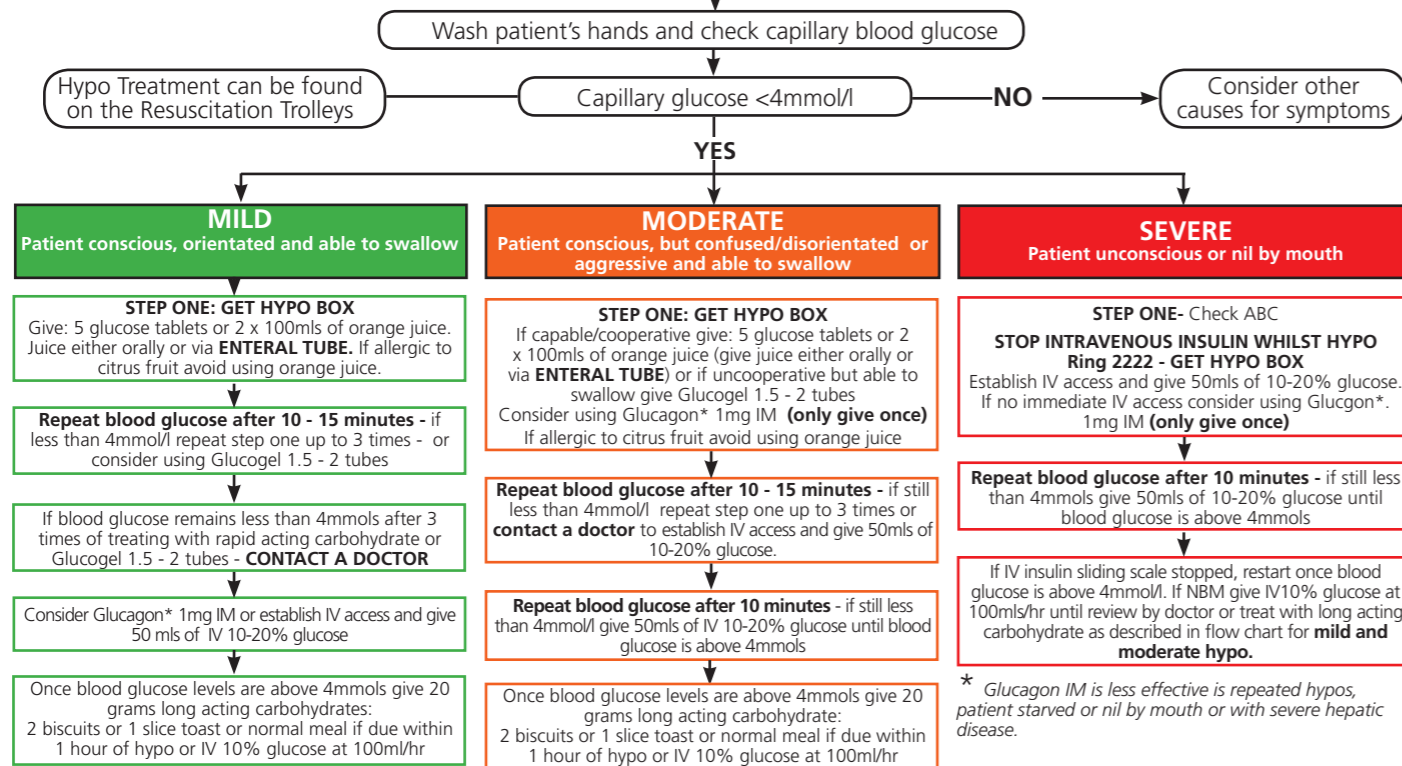
D.O.B: Male Female

Consultant:..... Ward:.....

HYPOGLYCAEMIA MANAGEMENT

- Record the initial capillary blood glucose reading in the correct section for capillary blood glucose recording on page 2 or 3. If less than 4mmol/l refer to WAHT-END-004 for the Treatment of Hypoglycaemia Flow Chart below for further guidance.
- Treatment for hypoglycaemia should be given under PGD and recorded in the appropriate section below. Alternatively this can be prescribed by a Doctor.
- For Paediatric patients (1 up to 16yrs of age) use half the recommended dose in the flow diagram below.**

Hypoglycaemia suspected - Patient complains of sweating, shaking, dizziness, tingling, confusion



MEDICINES GIVEN BY NURSING STAFF TO MANAGE HYPOGLYCAEMIA (under PGD) AS PER FLOW CHART

Date	Time	DRUG	Dose	Route	Signature	Print Name	Time

DOCUMENTATION OF CAPILLARY BLOOD GLUCOSE MONITORING

- After the hypoglycaemic episode has been treated record further capillary blood glucose readings in the table below.
- Repeat and record capillary blood glucose again 15 minutes after hypoglycaemia treatment is given.
- Continue to check and record capillary blood glucose readings every 15 minutes until 3 consecutive readings of 4.1mmol/l or greater are obtained. Regular blood glucose monitoring is then required every 2 to 4 hours for the next 24 hours.
- For recurrent hypoglycaemia refer the patient to the Diabetes Specialist Nurses for review.

DATE	TIME (00:00)	INITIALS	CAPILLARY BLOOD GLUCOSE READING MMOL/L	DATE	TIME (00:00)	INITIALS	CAPILLARY BLOOD GLUCOSE READING MMOL/L

PRESCRIPTION AND MONITORING CHART FOR SUBCUTANEOUS INSULIN INJECTIONS

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NAME:

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D.O.B: Male Female

Consultant:..... Ward:.....

ALLERGIES/ADVERSE DRUG REACTIONS		
NONE KNOWN <input type="checkbox"/>	Signature: _____	Date: _____
DATE	DRUG/FOOD/OTHER	REACTION DETAILS

PRE-ADMISSION DIABETES REGIMEN:

Approved drug name	Form / insulin device	Dose	Frequency

Diabetic Kit required: YES / NO Print Name _____ Signature _____ Date _____

Supplied by Pharmacy: _____ Print Name _____ Signature _____ Date: _____

INSULIN ADMINISTRATION:

Nurse/Midwife* Administration (Ref: MedPoISOPO9) Start _____ Stop _____

Self Administration (Ref: MedPoISOPO9) Start _____ Stop _____

Self Management Scheme (Ref: WAHT-CG-447) Start _____ Stop _____

* For the remainder of the chart where 'Nurse' is stated this also implies 'Midwife'.

HYPERGLYCAEMIA MANAGEMENT:

- Reference to WAHT-END-001 (Guidelines for the Treatment of Diabetic Ketoacidosis) & WAHT-END-006 (Management of the Initiation of Insulin in Adults.)

HYPOGLYCAEMIA MANAGEMENT:

- Record Management of Hypoglycaemia on page 4 of this document.
- Refer to WAHT-END-004 (Treatment of Hypoglycaemia Flow Chart on back page)

SAFE PRESCRIBING, ADMINISTRATION, TRANSFER AND STORAGE OF INSULIN

- When prescribing insulin, the word 'units' must never be abbreviated.
- Insulin doses must never be omitted or delayed unless clearly outlined on the prescription and documented in the medical notes by the prescriber.
- Prescribe 'Insulin as per chart' on the patient's main inpatient prescription chart.
- Prescribe and review insulin doses on a regular basis according to clinical need.
- Prescribe insulin doses to include all the doses required that day plus the morning dose of the following day
- Cross through all insulin prescription boxes not required that day.
- Cross off and re-write the prescription if changes are required.
- If changes in the patient's insulin regimen are required, as a general rule, alter one insulin prescription at a time be roughly 10% of the dose.
- Further dose adjustments should be made no less than 48 hourly.
- All insulin doses must be measured and administered using either an insulin syringe or a commercial pen device.
- Whenever a patient is moved between clinical areas, all insulin stored in the patient's bedside locker and ward fridge **must be transferred** with the patient.
- All insulin devices must be clearly labelled with the patients name and expiry date.
- Insulin devices in use must be stored in the patient's bedside locker and have a 4 week expiry from the date first used.
- Insulin devices not in use by the patient should be stored in the ward fridge. The expiry date for unused insulin will be the manufacturers.

TO BE FILED IN INPATIENT SECTION OF MEDICAL NOTES



PRESCRIPTION FOR SUBCUTANEOUS INSULIN INJECTIONS AND MONITORING CHART FOR MANAGEMENT OF DIABETES

Attach Patient Sticker here or record

NAME:
 NHS NO:
 HOSP NO:
 D.O.B: Male Female
 Consultant:..... Ward:.....

Target BM **7.0 - 11.0**mmol/L unless otherwise indicated
 Specify target range: mmol/L to mmol/L
 Signature: Date:

GUIDANCE ON CAPILLARY BLOOD GLUCOSE MONITORING: - Monitor blood glucose a **minimum** of 4 times daily (Pre-meals and at bedtime) **if pre-bedtime CBG is 7.0mmol/l or below check CBG at 03:00**
 - Specify if different frequency required:..... hourly

Specify insulin form and device(s):
 1. PHARMACY SUPPLY
 2.
 3.

PRESCRIBED INSULIN MUST NEVER BE OMITTED WITHOUT PRESCRIBER'S DOCUMENTED AUTHORISATION IN MEDICAL NOTES

		INSULIN DOSE IN UNITS				CAPILLARY BLOOD GLUCOSE (MMOL/L)					
		Blood glucose <4mmol/L needs action and treatment. Record 1st low blood glucose here and further blood glucose readings on page 4.				Blood glucose <4mmol/L needs action and treatment. Record 1st low blood glucose here and further blood glucose readings on page 4.					
DATE	INSULIN TYPE	Breakfast	Lunch	Tea	Bedtime	03:00	Pre-breakfast	Pre-lunch	Pre-tea	Pre-bedtime	Other eg. post meal, please specify
	Prescriber Signature/Bleep	UNITS Nurse Signature: Time given:	UNITS Nurse Signature: Time given:	UNITS Nurse Signature: Time given:	UNITS Nurse Signature: Time given:	READING mmol/L					
	Prescriber Signature/Bleep	UNITS Nurse Signature: Time given:	UNITS Nurse Signature: Time given:	UNITS Nurse Signature: Time given:	UNITS Nurse Signature: Time given:	Time taken					
	Prescriber Signature/Bleep	UNITS Nurse Signature: Time given:	UNITS Nurse Signature: Time given:	UNITS Nurse Signature: Time given:	UNITS Nurse Signature: Time given:	Signature					
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	Prescriber Signature/Bleep	UNITS Nurse Signature: Time given:	UNITS Nurse Signature: Time given:	UNITS Nurse Signature: Time given:	UNITS Nurse Signature: Time given:	Signature					

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		INSULIN DOSE IN UNITS				CAPILLARY BLOOD GLUCOSE (MMOL/L)					
		Blood glucose <4mmol/L needs action and treatment. Record 1st low blood glucose here and further blood glucose readings on page 4.				Blood glucose <4mmol/L needs action and treatment. Record 1st low blood glucose here and further blood glucose readings on page 4.					
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	Prescriber Signature/Bleep	UNITS Nurse Signature: Time given:	UNITS Nurse Signature: Time given:	UNITS Nurse Signature: Time given:	UNITS Nurse Signature: Time given:	Signature					
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