| SUBCUTANEOUS INSULIN SS | ROOM NO. |
|---|---|
| **ALLERGIES (list reactions):** | HT _____(Cm) WT_____(Kg) |

**A ☑ indicates a selected order. If a defaulted order is not appropriate or there is a change to an order, draw a line through the order and initial.**

**NURSING**

☐ Blood glucose monitoring (BGM)-AC and HS (recommended schedule: 0745,1100,1700,2100)
☐ Blood glucose monitoring (BGM)-AC
☐ Blood glucose monitoring (BGM)- Q 6 Hrs while patient is NPO
☐ Blood glucose monitoring (BGM)- postprandial: 2 Hr(s) after meals
☐ Blood glucose monitoring (BGM)- Q 4 Hrs
☐ Blood glucose monitoring (BGM)- daily at 0300
☑ Subcutaneous Insulin Orders:

- If patient is on an insulin infusion, discontinue infusion 2 Hrs after first basal (long-acting) insulin dose given.
- If TPN/Tube Feeds (Enteral feeding) interrupted, start D10% immediately and hold the basal insulin dose until TPN/feeding is resumed.
- If patient has 2 consecutive BG readings > 180, RN to discontinue current scale and enter new secondary order for next higher scale
- If patient has 2 consecutive BG readings > 180 and is on high dose scale, RN to contact MD to discuss additional glycemic control measures (i.e. –oral/basal insulin).
- For any BGM< 70 mg/dL, RN to discontinue current scale and enter secondary orders for next lower scale.
- If corrective and mealtime insulin are ordered ADD the corrective dose to the mealtime dose and give the TOTAL DOSE SubQ.

☑ Hypoglycemia Instructions are clinical instructions containing step by step directions regarding the administration of enteral nutrition for treatment of hypoglycemia. See clinical instructions below:

•For BG readings < 70 mg/dL; *Recheck* BG immediately. Using the second reading, follow the appropriate treatment orders, as applicable.
•Notify provider of all hypoglycemic episodes (BG < 70 mg/dL) and pt's response to hypoglycemic treatment.
•Check BG and give treatment Q 15 mins until BG ≥ 80 mg/dL, then recheck in 2 Hrs, re-notify provider if BG ≤ 80 mg/dL.
•If pt taking Po DM med and/or long acting insulin and meal not available for 2 Hrs give 15 Gm CHO snack then recheck BG in 2 Hrs.
•Give 4 OZ (120 mL) of juice/non diet soda Po Q 15 mins Prn BG = 60-69 mg/dL if pt is alert. Continue until BG ≥ 80 mg/dL.
•Give 6 OZ (180 mL) of juice/non diet soda Po Q 15 mins Prn BG = 50-59 mg/dL if pt is alert. Continue until BG ≥ 80 mg/dL.
•Give 8 OZ (240 mL) of juice/non diet soda Po Q 15 mins Prn BG < 50 mg/dL if pt is alert. Continue until BG ≥ 80 mg/dL.
•May give juice, non diet soda, dissolved glucose Tabs, via enteral tube (if pt has an enteral tube)
•Use Apple juice for renal transplant and renal failure pts.

☑ If BG < 70 mg/dL, RN to write a "HOLD" order for all insulin products ***and*** all oral diabetic meds using "secondary" as an order source. RN to notify provider of all medications on HOLD and get an order to resume insulin and/or oral diabetic medications from provider when applicable
☑ Notify MD of blood glucose for all BG readings > 400 or BG readings < 70.

**IV FLUIDS**

☑ Dextrose 10% IV to run at 40 mL/Hr Prn if TPN/Tube Feeds (Enteral feeding) are interrupted. Discontinue once TPN/feeding is resumed.

**MEDICATIONS**

REMINDER: For hospitalized patients with diabetes mellitus or nondiabetic hyperglycemia, avoid the routine use of biguanides Evidence (11658)

REMINDER: For hospitalized patients with diabetes mellitus or nondiabetic hyperglycemia, avoid the routine use of insulin sliding scale coverage alone for glycemic control; however, consider the use of an insulin sliding scale as one component of a multimodal glucose management protocol Evidence (11662)

REMINDER: For hospitalized patients with diabetes mellitus or nondiabetic hyperglycemia, consider the use of corrective-dose insulin therapy as one component of a multimodal glucose management protocol Evidence (195772)

REMINDER: For patients with known type 1 diabetes, basal insulin requirements should always be provided Evidence (11661)

Endocrine medications: Basal (long-acting) insulin orders

☐ Insulin Glargine (Lantus) ____units SubQ Daily. If patient is made NPO give 50% of the basal insulin dose. If patient is on an insulin infusion, discontinue infusion 2 Hrs after first basal (long-acting) insulin dose is given.

Endocrine medications: Mealtime (Prandial) insulin orders

☐ Insulin Aspart (NovoLOG) _____units SubQ AC BREAKFAST. Give 0-10 mins before or immediately after BREAKFAST if oral intake is uncertain. Hold dose if pt is made NPO or if meal is missed.

☐ Insulin Aspart (NovoLOG) _____units SubQ AC LUNCH. Give 0-10 mins before or immediately after LUNCH if oral intake is uncertain. Hold dose if pt is made NPO or if meal is missed.

☐ Insulin Aspart (NovoLOG) _____units SubQ AC DINNER. Give 0-10 mins before or immediately after DINNER if oral intake is uncertain. Hold dose if pt is made NPO or if meal is missed.

Endocrine medications: Corrective (sliding scale) insulin orders **AC and HS BG checks**

REMINDER: The use of corrective (sliding scale) insulin orders is not recommended as monotherapy for > 48 Hrs.

☐ Low Dose Scale - Insulin Aspart (NovoLOG) 300 units/3 mL syringe
Give 2 units SubQ Prn AC and HS BG 151-200, Give 4 units SubQ Prn AC and HS BG 201-250
Give 6 units SubQ Prn AC and HS BG 251-300, Give 8 units SubQ Prn AC and HS BG 301-350
Give 10 units SubQ Prn AC and HS BG 351-400, Give 12 units SubQ Prn AC and HS BG > 400.
Do not hold if patient is NPO.

☐ Medium Dose Scale - Insulin Aspart (NovoLOG) 300 units/3 mL syringe
Give 4 units SubQ Prn AC and HS BG 151-200, Give 8 units SubQ Prn AC and HS BG 201-250
Give 10 units SubQ Prn AC and HS BG 251-300, Give 12 units SubQ Prn AC and HS BG 301-350
Give 16 units SubQ Prn AC and HS BG 351-400, Give 20 units SubQ Prn AC and HS BG > 400.
Do not hold if patient is NPO.

☐ High Dose Scale_- Insulin Aspart (NovoLOG) 300 units/3 mL syringe
Give 8 units SubQ Prn AC and HS BG 151-200, Give 12 units SubQ Prn AC and HS BG 201-250
Give 16 units SubQ Prn AC and HS BG 251-300, Give 20 units SubQ Prn AC and HS BG 301-350
Give 24 units SubQ Prn AC and HS BG 351-400, Give 28 units SubQ Prn AC and HS BG > 400.
Do not hold if patient is NPO.

☐ Patient-Specific Scale - Insulin Aspart (NovoLOG) 300 units/3 mL syringe
Give ___units SubQ Prn AC and HS BG 151-200, Give ___ units SubQ Prn AC and HS BG 201-250
Give ___ units SubQ Prn AC and HS BG 251-300, Give ___ units SubQ Prn AC and HS BG 301-350
Give ___ units SubQ Prn AC and HS BG 351-400, Give ___ units SubQ Prn AC and HS BG > 400.
Do not hold if patient is NPO.

Endocrine medications: Corrective (sliding scale) insulin orders **AC BG checks only**
REMINDER: The use of corrective (sliding scale) insulin orders is not recommended as monotherapy for > 48 Hrs.

☐ Low Dose Scale - Insulin Aspart (NovoLOG) 300 units/3 mL syringe
Give 2 units SubQ Prn AC BG 151-200, Give 4 units SubQ Prn AC BG 201-250
Give 6 units SubQ Prn AC BG 251-300, Give 8 units SubQ Prn AC BG 301-350
Give 10 units SubQ Prn AC BG 351-400, Give 12 units SubQ Prn AC BG > 400. Do not hold if patient is NPO.

☐ Medium Dose Scale - Insulin Aspart (NovoLOG) 300 units/3 mL syringe
Give 4 units SubQ Prn AC BG 151-200, Give 8 units SubQ Prn AC BG 201-250
Give 10 units SubQ Prn AC BG 251-300, Give 12 units SubQ Prn AC BG 301-350
Give 16 units SubQ Prn AC BG 351-400, Give 20 units SubQ Prn AC BG > 400. Do not hold if patient is NPO.

☐ High Dose Scale - Insulin Aspart (NovoLOG) 300 units/3 mL syringe
Give 8 units SubQ Prn AC BG 151-200, Give 12 units SubQ Prn AC BG 201-250
Give 16 units SubQ Prn AC BG 251-300, Give 20 units SubQ Prn AC BG 301-350
Give 24 units SubQ Prn AC BG 351-400, Give 28 units SubQ Prn AC BG > 400. Do not hold if patient is NPO.

☐ Patient-Specific Scale - Insulin Aspart (NovoLOG) 300 units/3 mL syringe
Give ___units SubQ Prn AC BG 151-200, Give ___ units SubQ Prn AC BG 201-250
Give ___ units SubQ Prn AC BG 251-300, Give ___ units SubQ Prn AC BG 301-350
Give ___ units SubQ Prn AC BG 351-400, Give ___ units SubQ Prn AC BG > 400.
Do not hold if patient is NPO.

Endocrine medications: Mild Hypoglycemia medications
☑ Glucose 4 Gm Tabs, give 16 Gm Po Q 15 mins Prn BG = 60-69 mg/dL if juice/non diet soda not available. Continue until BG > or = 80 mg/dL. RN to contact pharmacy to enter NG order if pt cannot take by mouth.
☑ Dextrose 50%, 25 mL IV Push Q 15 mins Prn BG = 60-69 mg/dL if pt is NPO, not alert enough to take Po's, or markedly symptomatic for hypoglycemia. Continue until BG > or = 80 mg/dL.

Endocrine medications: Moderate Hypoglycemia medications
☑ Glucose 4 Gm Tabs, give 20 Gm Po Q 15 mins Prn BG = 50-59 mg/dL if juice/non diet soda not available. Continue until BG > or = 80 mg/dL. RN to contact pharmacy to enter NG order if pt cannot take by mouth.
☑ Dextrose 50%, 25 mL IV Push Q 15 mins Prn BG = 50-59 mg/dL if pt is NPO, not alert enough to take Po's, or markedly symptomatic for hypoglycemia. Continue until BG > or = 80 mg/dL.

Endocrine medications: Severe Hypoglycemia medications
☑ Glucose 4 Gm Tabs, give 32 Gm Po Q 15 mins Prn BG < 50 mg/dL if juice/non diet soda not available. Continue until BG > or = 80 mg/dL. RN to contact pharmacy to enter NG order if pt cannot take by mouth.
☑ Dextrose 50%, 50 mL IV Push Q 15 mins Prn BG **<** 50 mg/dL if pt is NPO, not alert enough to take Po's, or markedly symptomatic for hypoglycemia. Continue until BG > or = 80 mg/dL.
☑ Glucagon 1 mg IM Q 20 mins x 2 doses Prn BG < 50 mg/dL if the pt does not have IV access**.** Reconstitute with 1 mL of sterile water for injection to yield a 1 mg/mL solution. May give SubQ if unable to give IM.

**CONSULTS**
REMINDER: Consider specialty referral (for Endocrinologist)
☐ Consult Dr._____