CUT OFF SECTION

NSW GOVERNMENT Health

Facility/Service:.....

Ward/Unit: .....

ALERTS

☐ Nil

Notify doctor _____ if; _____

OR

BGL less than _____ mmol/L OR BGL greater than _____ mmol/L

OR

Blood ketones greater than _____ mmol/L

OR

Urine ketones _____

Prescriber Signature: _____ Print Name: _____

Reason for nurse not administering insulin Codes MUST be circled	
Absent	(A)
Fasting	(F)
Refused-notify Dr	(R)
Vomiting-notify Dr	(V)
On Leave	(L)
Not Available - obtain supply or contact doctor and generate incident report	(N)
Withheld-Enter reason in clinical record	(W)
Self Administering	(S)

☐ **Insulin pump - Order type of insulin on this chart. Write "insulin pump" in 'frequency' box and sign order. Document dosing in notes**

☐ **Other diabetes medication on National Inpatient Medication Chart (NIMC)**

Special Instructions

DATE	INSTRUCTIONS	NAME (DESIGNATION)		SIGNATURE

Instructions for Using Prescribing Chart

- All Insulin prescription orders except intravenous (IV) infusions are to be recorded on this chart.
- Patients receiving subcutaneous insulin are to have their blood glucose levels (BGL) and ketones recorded on this chart.
- Specify the frequency of BGL monitoring (page 3). Tick as appropriate. Patients with unstable BGLs require more frequent monitoring.
- All patient management must also be documented in the patient's health care records.

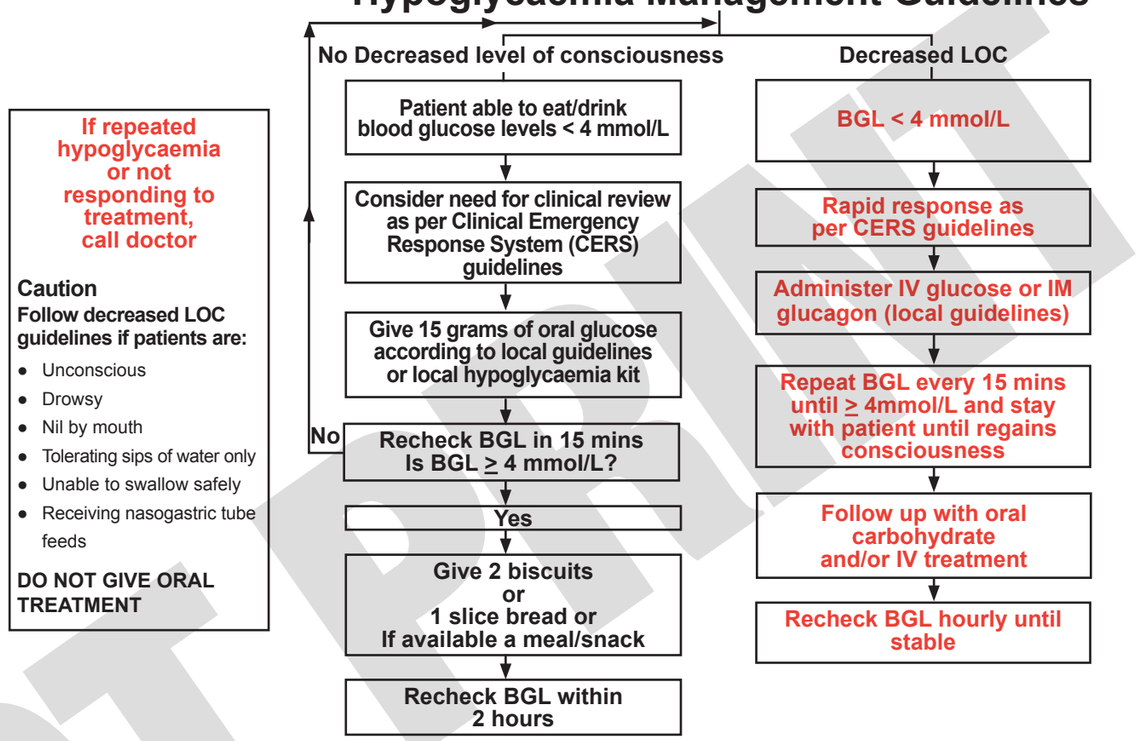
Insulin Prescription and Administration Guidelines

- Evidence based practice is to manage a patient with a basal-bolus-supplemental (booster) insulin regimen. Advice should be sought for other clinical practice.
- **Daily review and prescribing of insulin is recommended** as requirements can often vary whilst in hospital. Insulin may be prescribed in advance if the patient's glycaemic status is stable.
- Insulin requirements should be modified peri-operatively or when dietary intake is modified.
- For most patients the **target BGL range is 5-10mmol/L**, pregnancy is an exception.
- The word "units" has been pre-printed. Write the numeric value only.
- If any changes are to be made to the order - (eg. insulin type or dose), a completely new order is to be written. No alteration should be made to the original order.
- To discontinue an insulin order, the prescriber will draw two oblique lines in the administration column on the day of discontinuation and sign and date it. A single oblique line is drawn through the insulin name.
- The preferred site of insulin injection is the abdomen.

SUBCUTANEOUS INSULIN CHART AND BLOOD GLUCOSE CHART FOR ADULTS

SMR130.035

Hypoglycaemia Management Guidelines



If repeated hypoglycaemia or not responding to treatment, call doctor

Caution

Follow decreased LOC guidelines if patients are:

- Unconscious
- Drowsy
- Nil by mouth
- Tolerating sips of water only
- Unable to swallow safely
- Receiving nasogastric tube feeds

DO NOT GIVE ORAL TREATMENT

- Identify and treat the cause of hypoglycaemia and document in the patient's health care records
- If the patient is hypoglycaemic when the next dose of insulin is due, delay administration until after correction of the hypoglycaemia. **Do not omit insulin**, consider dose review.

Hyperglycaemia Management Guidelines

- Identify and treat the cause of hyperglycaemia and document in the patient's health care record.
- Review current insulin regimen and adjust doses as necessary (requirements can change as the patient's clinical status alters).
- Consider commencement of an insulin infusion if the patient is nil by mouth, vomiting or if hyperglycaemia persists (according to local guidelines).
- Check ketones if type 1 diabetes and BGL is > 15 mmol/L then follow local guidelines.

Supplemental Insulin and Correction of Hyperglycaemia

- The patient's usual diabetes treatment, particularly insulin requirements, should be reviewed at least daily in the acute phase of their illness and adjusted as appropriate.
- **Supplemental insulin is not a replacement for regular antihyperglycaemic therapy and should not be used in isolation.**
- Supplemental insulin is best given before a meal, in addition to the patient's usual insulin doses, in order to prevent post meal hyperglycaemia.
- When prescribing supplemental insulin, state (1) the BGL range for each dose of insulin (2) the timing and frequency of administration. It is preferable to use the insulin analogues, NovoRapid (aspart), Humalog (lispro) or Apidra (glulisine) due to their more rapid onset and shorter duration of action.
- **Use local guidelines for supplemental insulin. Otherwise this guide may be used:**

If BGL range before meals is:	10-12 mmol/L	Give 2 units of rapid acting insulin
	12.1-18 mmol/L	Give 4 units of rapid acting insulin
	18.1-20 mmol/L	Give 6 units of rapid acting insulin
	>20 mmol/L	Call for clinical review

Note: Supplemental guide may need modification depending on patient's insulin sensitivity, weight and individual needs.

- Multiple doses of supplemental insulin given within a short time frame (e.g. less than every 4 hours) may have an additive effect and result in hypoglycaemia.
- If significant hyperglycaemia persists, consider an insulin infusion (according to local guidelines).

SMR130035

SMR130035

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

Attach ADR Sticker

ALLERGIES & ADVERSE DRUG REACTIONS (ADR) ☐ Nil known ☐ Unknown (tick appropriate box or complete details below)		
Drug (or other)	Reaction/Date	Initials

Sign .... Print .... Date ....

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ______/______/______	M.O. NOT A VALID
ADDRESS	PRESCRIPTION UNLESS
	IDENTIFIERS PRESENT
LOCATION	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

First Prescriber to Print Patient Name and Check Label Correct: .... Weight(kg):................ Height(cm):................

CUT OFF SECTION

REGULAR SUBCUTANEOUS INSULIN PRESCRIPTION RECORD

	Date	Type of Insulin	Date	Type of Insulin	Date	Type of Insulin
	Frequency	Pharmacy	Frequency	Pharmacy	Frequency	Pharmacy
	Prescriber Signature / Print name	Contact	Prescriber Signature / Print name	Contact	Prescriber Signature / Print name	Contact

Circle AND / OR specify time	Pre B/Fast	Pre Lunch	Pre Dinner	Bed Time	Pre B/Fast	Pre Lunch	Pre Dinner	Bed Time	Pre B/Fast	Pre Lunch	Pre Dinner	Bed Time
Date – Dose	Units	Units	Units	Units	Units	Units	Units	Units	Units	Units	Units	Units
Prescriber (sign)												
Nurse												
Time given												
Date – Dose	Units	Units	Units	Units	Units	Units	Units	Units	Units	Units	Units	Units
Prescriber (sign)												
Nurse												
Time given												
Date – Dose	Units	Units	Units	Units	Units	Units	Units	Units	Units	Units	Units	Units
Prescriber (sign)												
Nurse												
Time given												
Date – Dose	Units	Units	Units	Units	Units	Units	Units	Units	Units	Units	Units	Units
Prescriber (sign)												
Nurse												
Time given												
Date – Dose	Units	Units	Units	Units	Units	Units	Units	Units	Units	Units	Units	Units
Prescriber (sign)												
Nurse												
Time given												

BLOOD GLUCOSE AND KETONE MONITORING

BGL Frequency (Tick box) ☐ Before meals ☐ 2 hours after meals ☐ 2200 hrs ☐ 0200-0300 hrs ☐ Other Specify: ____________

Check ketones if Type 1 diabetes and BGL is >15mmol/L

	0200 - 0300 hrs	Breakfast Pre	Breakfast Post	Lunch Pre	Lunch Post	Dinner Pre	Dinner Post	Bed Time 2200 hrs
Time / BGL								
Time / BGL								
Ketones								
Time / BGL								
Time / BGL								
Ketones								
Time / BGL								
Time / BGL								
Ketones								
Time / BGL								
Time / BGL								
Ketones								
Time / BGL								
Time / BGL								
Ketones								

Hypoglycaemia Treatment Record

Time	BGL	Action	Sign	Time	BGL	Action	Sign

SUPPLEMENTAL (BOOSTER) ORDER TO BE USED IN ADDITION TO PATIENT'S USUAL DIABETES TREATMENT. SEE GUIDELINES PAGE

Type of Insulin	Frequency	
Prescriber Signature	Print name	Contact

Administration Times:
☐ Before meals OR ☐ Specify: ______________

If BGL range: ______________ Give ________ units
If BGL range: ______________ Give ________ units
If BGL range: ______________ Give ________ units
If BGL range: ______________ Give ________ units
If BGL range: ______________ Give ________ units
Notify MO if BGL __________ mmol/L

Record of Administration

Date		Date		Date		Date		Date	
Dose given	Time/given by	Dose given	Time/given by	Dose given	Time/given by	Dose given	Time/given by	Dose given	Time/given by
Units	:	Units	:	Units	:	Units	:	Units	:
Units	:	Units	:	Units	:	Units	:	Units	:
Units	:	Units	:	Units	:	Units	:	Units	:
Units	:	Units	:	Units	:	Units	:	Units	:

ONCE ONLY ORDER

Date	Type of Insulin	Dose	Date/Time of dose	Prescriber: Print Name	Signature	Contact	Administration: Date	Time Given	Given by
		Units							
		Units							
		Units							
		Units							

TELEPHONE ORDERS (to be signed by prescriber within 24 hours of order)

Date	Time	Type of Insulin	Dose	Nurse Initials Nr 1/Nr 2	Prescriber: Print Name	Signature	Contact	Administration: Date	Date/Time Given	Given by
			Units							
			Units							
			Units							
			Units							