Plymouth Hospitals NHS
NHS Trust

Unknown insulin regimen in Adult patients admitted acutely unwell

Patients with diabetes admitted to hospital acutely unwell or with chronic confusion/cognitive impairment may not know their usual medications/doses, including insulin. Try to identify the correct insulin regimen (section 1) but if not possible, sections 2 &3 provide a management guide to minimise the risk of hypo/hyperglycaemia until the patient's usual regimen can be ascertained. In all cases, contact the Diabetes in-patient team (bleep **0989 or 85694**) for on-going management as soon as able.

For patients admitted on an insulin pump, please see separate guideline: "Managing insulin pumps in hospitalised patients".

Section 1: Identifying the patient's usual insulin regimen

1. Ask the patient! He/she may not remember the dose, but may know *which* insulin(s) they take, or vice versa.
2. Ask to see the patient's insulin pens(s) and monitoring book: many patients document their current insulin doses in their monitoring book.
3. Ask a family member: he/she may have the correct information, or may be able to provide the patient's insulin passport, detailing which insulin is taken, even if not the current dose.
4. Contact the patient's GP surgery: this will allow you to identify *which* insulin is prescribed, but unless the patient has been seen in the GP practice very recently (i.e. within last month), any record of insulin *dose* cannot be certain.
5. Some patients have their insulin administered by district nurses or nursing home staff: contact the NH/DN team for further information.

Section 2: Short term management when insulin regimen unknown

1. If the patient is suspected to have type 1 diabetes (or if T1DM is a possibility)*, but is unable to recall either which insulin he/she takes or the usual dose
OR if patient unwell (e.g. vomiting/sepsis)

Start VRII (variable intravenous insulin infusion) using the unstable diabetes protocol, and monitor capillary blood glucose (BG) regularly (frequency of monitoring determined by clinical state; may need to be hourly). If BG >14, measure finger-prick blood ketone level. Do not stop VRII until patient recovered, and usual insulin/dose known and prescribed.

2. Is it suspected that the patient has type 2 diabetes* and is not usually on insulin?

Monitor BG 4-hourly: if 2 consecutive BG levels >14 mmol/l, start VRII and check blood ketones.

***Type 2 DM is more likely if the patient is obese (BMI>30) and older age at time of original diagnosis, and/or if hyperglycaemic yet not acidotic/ketotic.**

Type 1 DM is more likely if patient is of normal weight and younger age at time of diagnosis, and/or has had admissions with DKA.

Dr K Evans, Consultant Physician
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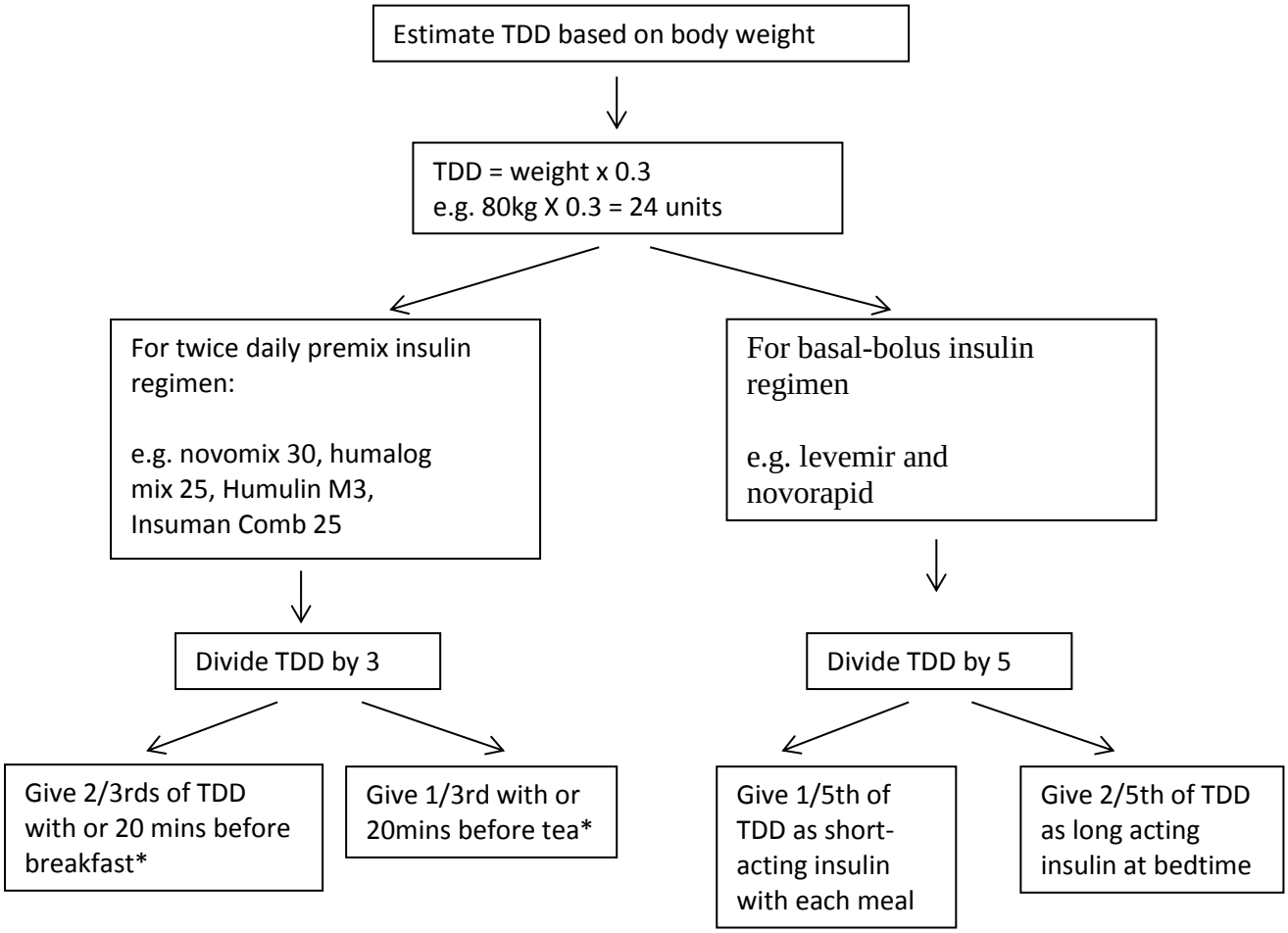
3. The type of insulin is known (e.g. levemir and novorapid) but not the dose despite following the steps above?

Calculate a safe total daily dose (TDD) based on body weight as below.
This dose should be sufficient to prevent development of ketoacidosis but be very unlikely to cause hypoglycaemia. Document in the additional information box on the drug chart and the medical notes that the dose has been calculated from body weight and the patient's usual dose needs to be confirmed. This can then be followed up by the medical team or ward Pharmacist.

Monitor BG levels at least 4/day pre meal/bed, and titrate insulin doses as required.



*give 20mins before meal if non-analogue insulin i.e. Insuman Comb25 or Humulin M3

Trust Guidelines	Plymouth Hospitals NHS NHS Trust

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Accountabilities	
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Links to other documents

Version History		
	Version 1	December 2012
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