

## MATERNITY GUIDELINES

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### Diabetes Mellitus

#### Management of Pre-existing and Gestational diabetes in pregnancy

#### Navigation

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#### **1. Diabetes in pregnancy overview**

The main types of diabetes likely to be encountered in pregnancy are:

- Type 1 diabetes
- Type 2 diabetes
- Gestational diabetes (GDM) i.e., diabetes detected in pregnancy.

- Specific types of diabetes due to other causes.  
This may include women with monogenic diabetes or maturity-onset diabetes of the young (MODY), cystic fibrosis, pancreatitis and chemical or drug induced diabetes

Blood glucose targets are kept within a specific range throughout pregnancy (4.0-7.8 mmol/l). Ensure meters/sensors are set to this.

## **2. Diabetes/Obstetric service set up**

- **Pre-existing diabetes (type 1 and 2):**

Tuesday Morning joint clinic - referral as soon as positive pregnancy test

**Offer a clinic appointment as soon as pregnancy confirmed - Tuesday morning joint diabetes/ obstetric clinic. Patients can be seen prior to community midwife booking.**

Women are to attend clinic every 1-3 weeks during pregnancy  
Weekly appointments from 32 weeks gestation

- **Gestational diabetes:**

Clinics held Monday and Friday morning

### **Scans (women with pre-existing diabetes):**

- Early dating scan to confirm gestation
- 12 and 20 week scan
- Growth scans from 28 weeks as per growth scan protocol
- **Community Midwife:**

All women are encouraged to continue their usual community midwifery appointments.

- **Triage visits:**

Women are encouraged to contact triage if they have a reduction in fetal movements or reduced insulin requirements.

## **3. Type 1 Diabetes management**

Women will be managed on a basal bolus regime or insulin pump therapy. They will also be using a flash glucose sensor to scan their glucose during pregnancy; however they will also require capillary BG tests whilst in hospital.

Capillary Ketone testing is required if blood glucose levels above 10 mmol/l.

Women to record pre and post blood glucose readings (at least 8 tests per day) in their orange obstetric notes for clinic review.

#### **4. Type 2 Diabetes management**

Women will be managed on a combination of metformin and insulin during pregnancy. All other diabetes medications should be discontinued and have an urgent referral to antenatal clinic.

#### **5. General management for all women with pre-existing diabetes**

All women with pre-existing diabetes are encouraged to take **folic acid 5mg** for three months prior to conception until after their 12 week scan.

Aspirin 150mg to be commenced at 12 weeks gestation unless contraindicated.

Risk assess for clexane use in pregnancy.

#### **Eye Screening:**

All women with pre-existing diabetes will be referred to the retinal eye service for closer surveillance in pregnancy. The referral will be made by the diabetes team in clinic

#### **Blood Glucose Targets:**

- 4- 5.3 mmol/L pre-meal
- 7.8 mmol/L or less one hour post meal
- Capillary Glucose testing and /or flash glucose sensor use.

Encouraged to test 8 times per day and record pre and post meal results in handheld notes.

#### **Hypoglycaemia:**

Counsel women regarding risks of hypoglycaemia in pregnancy and ensure they carry suitable hypo treatment.

#### **Blood and Urine Testing during pregnancy:**

- **HbA1c**

Baseline test, at booking and once in third trimester. Can be done more frequently, however not to be relied upon for reassurance of stability in diabetes control during pregnancy.

- **Thyroid Function**

Baseline test in first trimester- to be repeated every trimester if requiring treatment.

- **Renal Function**

Baseline U&Es and urine protein/creatinine ratio  
Repeat in every trimester if abnormal result

If known renal complications of diabetes then refer to nephrology team.

## 6. Steroids and diabetes management

It is to be expected that maternal glucose levels will rise for a period of time after steroids are given, necessitating close monitoring and increased insulin doses. **See appendix 1 for steroids and diabetes management.**

## 7. Diabetic ketoacidosis (DKA) in Pregnancy

### Diagnosis of DKA:

1. Presence of diabetes **and**
2. **Ketosis:** urinary ketones >2 or blood ketones >3.0 mmol/l (high risk 1.5mmol) **AND**
3. **Acidosis:** Blood gas Ph <7.3 and/or bicarbonate <15 (NB Bicarb is reduced in pregnancy). Use venous blood gas.

Issue all women with type 1 diabetes, blood ketone test strips. Advise to test for ketones if blood glucose is above 10 mmols or they feel unwell.  
Hospital admission if ketones are 1.0 mmol/l or above.

### Treatment of DKA:

#### Use UHPT DKA protocol.

- Involve the medical or diabetes team urgently
- DKA in pregnancy should be managed in HDU or ICU
- One hourly blood glucose, using hospital calibrated meter
- Glucose level is not an accurate indicator of resolution of acidosis in euglycaemic ketoacidosis, so the acidosis resolution should be verified by venous gas analysis.
- Continue basal insulin throughout (Lantus, Toujeo, Levemir, Tresiba, Abasaglar).

If the woman is using an insulin pump advise them to discontinue the pump and start insulin infusion as per protocol.

## 8. Intrapartum care

**See appendix 2 for glucose management during labour**

**See appendix 3 for insulin pump management during labour**

### TIMING OF DELIVERY:

As per NICE guidance:

Advise pregnant women with type 1 or type 2 diabetes and no other complications to have an elective birth by induction of labour, or by elective caesarean section if indicated, between 37<sup>+0</sup> weeks and 38<sup>+6</sup> weeks of pregnancy.

**Consider elective birth before 37<sup>+0</sup> weeks for women with type 1 or type 2 diabetes if there are metabolic or any other maternal or fetal complications.**

Advise women with gestational diabetes to give birth no later than 40<sup>+6</sup> weeks, and offer elective birth (by induction of labour, or by caesarean section if indicated) to women who have not given birth by this time.

**Consider elective birth before 40<sup>+6</sup> weeks for women with gestational diabetes if there are maternal or fetal complications.**

Diabetes should not in itself be considered a contraindication to attempting vaginal birth after a previous caesarean section.

Explain to pregnant women with diabetes who have an ultrasound-diagnosed macrosomic fetus about the risks and benefits of vaginal birth, induction of labour and caesarean section.

Admit women with pre-existing diabetes to triage for assessment if they report reduced insulin requirements and/or reduced fetal movements.

Women with co-morbidities such as obesity or autonomic neuropathy should be offered an anaesthetic assessment in the third trimester.

Delivery prior to 34 weeks gestation may require administration of steroids for fetal lung maturation- hourly blood glucose monitoring will be required. Additional insulin will be required in women with Type 1 diabetes.

## **9. Postnatal care for women with Type 1 and 2 Diabetes**

Women with insulin treated pre-existing diabetes should reduce their insulin immediately after delivery to their pre pregnancy insulin doses and monitor levels closely to avoid hypoglycaemia.

If planning to breastfeed then a 25% reduction on pre- pregnancy insulin doses will be required.

- Women with type 2 diabetes can continue to take metformin whilst breastfeeding.
- A consultant review will be organised after 6 weeks.
- Women will be reviewed in the diabetes postnatal clinic.
- Contraception advice- CASH referral if needed.

## **10. Gestational diabetes (GDM)**

A glucose tolerance test (GTT) is required to diagnose gestational diabetes.

**For women unable to tolerate a GTT a glucose meter should be issued and they should be advised to test their capillary glucose levels for one week then arrange a GDM clinic follow up.**

- **GTT at 12 weeks for any women with previous GDM.**
- **GTT between 24-28 weeks for at-risk women**

Abnormal GTT in pregnancy is diagnosed if the fasting blood glucose is  $>5.3$  or a 2 hourly result of  $>7.8$ .

After diagnosis of GDM a referral should be made to the antenatal clinic where a blood glucose meter will be issued and a dietitian will be available for advice. An appointment will be arranged for a growth scan and GDM consultant appointment.

- **Baseline HbA1c** should be performed at diagnosis to identify anyone at risk of pre-existing diabetes. If the result is greater than 48 mmols/l then it could indicate pre-existing type 1 or 2 diabetes- refer to the Tuesday Diabetes/ obstetric clinic for follow up.
- Blood Glucose targets are 5.3 or less on fasting and 7.8 or less one hour post prandially. If blood glucose is not within parameters then Metformin is prescribed (unless there are any contraindications to its use). Metformin is started at 500mg once a day and slowly titrated to a maximum of 2g per day as tolerated/ required.
- **If Metformin is not tolerated or blood glucose levels are above 10 mmols/l then insulin should be started.**
- Women with GDM will be offered growth scans (as per current scanning guidelines).

#### **IF GDM is suspected after 36 weeks:**

If GDM is suspected after 36 weeks gestation then issue a glucose meter and advise the woman to test 4 times per day (fasting glucose and 1 hr after each meal) for one week. They will be seen in a DSM/N clinic the following week for review and a plan. A letter to the GP should be made at this time.

If there are 3 or more blood glucose readings above target then a late diagnosis of GDM is made. Orange notes should be issued and then a plan made re: treatment and delivery.

#### **Postnatal plan for GDM:**

- Discontinue metformin/insulin unless otherwise advised
- 6 Week postnatal fasting plasma glucose at GP surgery
- Annual HbA1c
- Weight Management referral if appropriate
- Contraception Advice

**Intravenous Insulin Prescription and Fluid Protocol  
FOR MANAGEMENT OF STEROID HYPERGLYCAEMIA DURING PREGNANCY**

<p>For use for ALL patients receiving Variable Rate Intravenous Insulin Infusion (VRIII) for the management of steroid hyperglycaemia during pregnancy NEVER use an IV syringe to draw up insulin ALWAYS draw up insulin using an insulin syringe ALWAYS continue subcutaneous intermediate* or basal insulin** *Intermediate: Insulatard, Humulin I, Insuman basal **Basal: Lantus (Glargine), Levemir (Detemir), Tresiba (Degludec), Toujeo Doctor: All prescriptions for insulin and fluids must be signed Nurse: All entries must be signed</p>	<b>Ward</b>	<b>Consultant</b>	Admission Date:	
			Discharge Date:	
	Surname		First Name	
	Hospital Number		Date of Birth / Age	
	NHS Number			
	Address			

DOSING ALGORITHM (Please see the guide below)				ALGORITHM GUIDE	
Algorithm	1	2	3		
	For most women	For women not controlled on algorithm 1 or needing >80 units/day of insulin	For women not controlled on algorithm 2 (after specialist advice)	<ul style="list-style-type: none"> <li>ALL women with diabetes should have Capillary Blood Glucose (CBG) testing hourly whilst on VRIII for the management of steroid hyperglycaemia during pregnancy</li> <li>Start VRIII and Fluids with the first dose of steroids and continue for up to 24 hours after the last dose</li> </ul>	
CBG Levels (mmol/L)	Infusion Rate (units/hr = ml/hr)			<b>Algorithm 1</b> Most women will start here  <b>Algorithm 2</b> Use this algorithm for women who are likely to require more insulin (on steroids; on >80 units of insulin during pregnancy; or those not achieving target on algorithm 1)  <b>Algorithm 3</b> Use this for women who are not achieving target on algorithm 2 (No patient starts here without diabetes or medical review)	
<4	STOP INSULIN FOR 20 MINUTES Treat hypo as per guideline (re-check CBG in 10 minutes)			<b>Algorithm 3</b> Use this for women who are not achieving target on algorithm 2 (No patient starts here without diabetes or medical review)	
4.0 – 5.5	0.2	0.5	1.0	If the woman is not achieving targets with these algorithms, contact the diabetes team (out of hours: Medical SpR on call)	
5.6 – 7.0	0.5	1.0	2.0		
7.1 – 8.5	1.0	1.5	3.0		
8.6 – 11.0	1.5	2.0	4.0		
11.1 – 14.0	2.0	2.5	5.0		
14.1 – 17.0	2.5	3.0	6.0		
17.1 – 20.0	3.0	4.0	7.0		
>20.1	4.0	6.0	8.0	Target CBG level = 4 – 7.8 mmol/L Check CBG every hour whilst on VRIII Move to the higher algorithm if the CBG is > target and is not dropping Move to the lower algorithm if CBG falls below 4 mmol/L or is dropping too fast	
Signed					
Print Name					
Date					

Drug (approved name) Please tick	Dose	Volume	Route	Prescriber's Signature	Prescriber Print name	Date	SYRINGE PREPARATION				
Human Actrapid <input type="checkbox"/>	50 UNITS	Made up to 50ml with NaCl 0.9% (1 UNIT per ml)	IV				Prepared and administered by	Date	Time started	Time stopped	
Humulin S <input type="checkbox"/>											
INTRAVENOUS SUBSTRATE FLUID PRESCRIPTION											
Date	Intravenous Fluid and Rate			Alternative Rate	Prescriber's Signature	Nurse's Signature					
	500 ml 0.9% NaCl + 5% Dextrose with 20 mmol KCl/L (0.15%) to run at 50 ml/hr										
	500 ml 0.9% NaCl + 5% Dextrose with 20 mmol KCl/L (0.15%) to run at 50 ml/hr										

PRESCRIPTION OF INTRAVENOUS MANAGEMENT OF HYPOGLYCAEMIA									
Date	Time	Preparation	Volume	Route	Duration	Prescriber's Signature	Print Name	Given by:	Time given
		20% Dextrose	100 mls	IV	15 mins				

Patients with type 1 DM on insulin pumps should be referred to the Diabetes Specialist Team on SALUS

Maintain IV insulin infusion for 30 minutes after re-starting original insulin regime – IV insulin has a 5 minute half-life



INTRAVENOUS INSULIN, CBG AND KETONES MONITORING RECORD SHEET	
<p><b>Guide:</b> Only use for patients on intravenous insulin regimen. Use different chart for patients on subcutaneous insulin. Make sure the patient's hands are clean. Check CBG hourly for further 24 hrs after last steroid dose OR as per advice from Diabetes team</p>	<p>Address label</p>

Date	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00	10:00	11:00	12:00
CBG												
Insulin rate												
Blood ketones												
Initials												
Date	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00
CBG												
Insulin rate												
Blood ketones												
Initials												
Date	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00	10:00	11:00	12:00
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Insulin rate												
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CBG												
Insulin rate												
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Initials												

Patients with type 1 Diabetes on insulin pumps should be referred to the Diabetes team on SALUS.  
Maintain IV insulin infusion for 30 minutes after re-starting original insulin regime – IV insulin has a 5 minute half-life

Authors: Dr Kate Evans, Mrs Emma Green.  
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HRSG number:



Appendix 2: Diabetes management during labour



**Intravenous Insulin and Fluid Prescription  
PREGNANCY AND LABOUR ONLY**

For use during pregnancy and labour for ALL patients receiving Variable Rate Intravenous Insulin Infusion (VRIII) NEVER use an IV syringe to draw up insulin ALWAYS draw up insulin using an insulin syringe ALWAYS continue subcutaneous intermediate\* or basal insulin\*\*  
\*Intermediate: Insulatard, Humulin I, Insuman basal  
\*\*Basal: Lantus (Glargine), Levemir (Detemir), Tresiba (Degludec), Toujeo  
Doctor: All prescriptions for insulin and fluids must be signed  
Nurse: All entries must be signed

Ward	Consultant	Admission Date:
		Discharge Date:
Surname	First Name	
Hospital Number	Date of Birth / Age	
NHS Number		
Address		

DOSING ALGORITHM (Please see the guide below)				ALGORITHM GUIDE	
Algorithm	1	2	3		
	For most women	For women not controlled on algorithm 1 or needing >80 units/day of insulin	For women not controlled on algorithm 2 (after specialist advice)		
CBG Levels (mmol/L)	Infusion Rate (units/hr = m/hr)				
<4	STOP INSULIN FOR 20 MINUTES Treat hypo as per guideline (re-check CBG in 10 minutes)				
4.0 – 5.5	0.2	0.5	1.0	Algorithm 1 Most women will start here	
5.6 – 7.0	0.5	1.0	2.0	Algorithm 2 Use this algorithm for women who are likely to require more insulin (on steroids; on >80 units of insulin during pregnancy; or those not achieving target on algorithm 1)	
7.1 – 8.5	1.0	1.5	3.0	Algorithm 3 Use this for women who are not achieving target on algorithm 2 (No patient starts here without diabetes or medical review)	
8.6 – 11.0	1.5	2.0	4.0		
11.1 – 14.0	2.0	2.5	5.0		
14.1 – 17.0	2.5	3.0	6.0		
17.1 – 20.0	3.0	4.0	7.0		
>20.1	4.0	6.0	8.0	If the woman is not achieving targets with these algorithms, contact the diabetes team (out of hours: Medical SpR on call)	
Signed				Target CBG level = 4 – 7 mmol/L	
Print Name				Check CBG every hour whilst on VRIII and every half an hour if under anaesthesia	
Date				Move to the higher algorithm if the CBG is > target and is not dropping	
				Move to the lower algorithm if CBG falls below 4 mmol/L or is dropping too fast	

Drug (approved name)	Dose	Volume	Route	Prescriber's Signature	Prescriber Print name	Date	SYRINGE PREPARATION			
Human Actrapid Humulin S	50 UNITS	Made up to 50ml with NaCl 0.9% (1 UNIT per ml)	IV				Prepared and administered by	Date	Time started	Time stopped

INTRAVENOUS SUBSTRATE FLUID PRESCRIPTION					
Date	Intravenous Fluid and Rate	Alternative Rate	Prescriber's Signature	Nurse's Signature	
	500 ml 0.9% NaCl + 5% glucose with 20 mmol/L KCl (0.15%) to run at 50 ml/hr				
	500 ml 0.9% NaCl + 5% Dextrose with 20 mmol KCl/L (0.15%) to run at 50 ml/hr				

PRESCRIPTION OF INTRAVENOUS MANAGEMENT OF HYPOGLYCAEMIA									
Date	Time	Preparation	Volume	Route	Duration	Prescriber's Signature	Print Name	Given by:	Time given
		20% Dextrose	100 mls	IV	15 mins				

CAPILLARY BLOOD GLUCOSE MONITORING													GESTATIONAL DIABETES: STOP VRIII and IV Substrate Fluid regime once placenta is delivered	
Date	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00	10:00	11:00	12:00		
CBG														
Insulin rate														
Blood ketones														
Initials														
Date	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00		
CBG														
Insulin rate														
Blood ketones														
Initials														

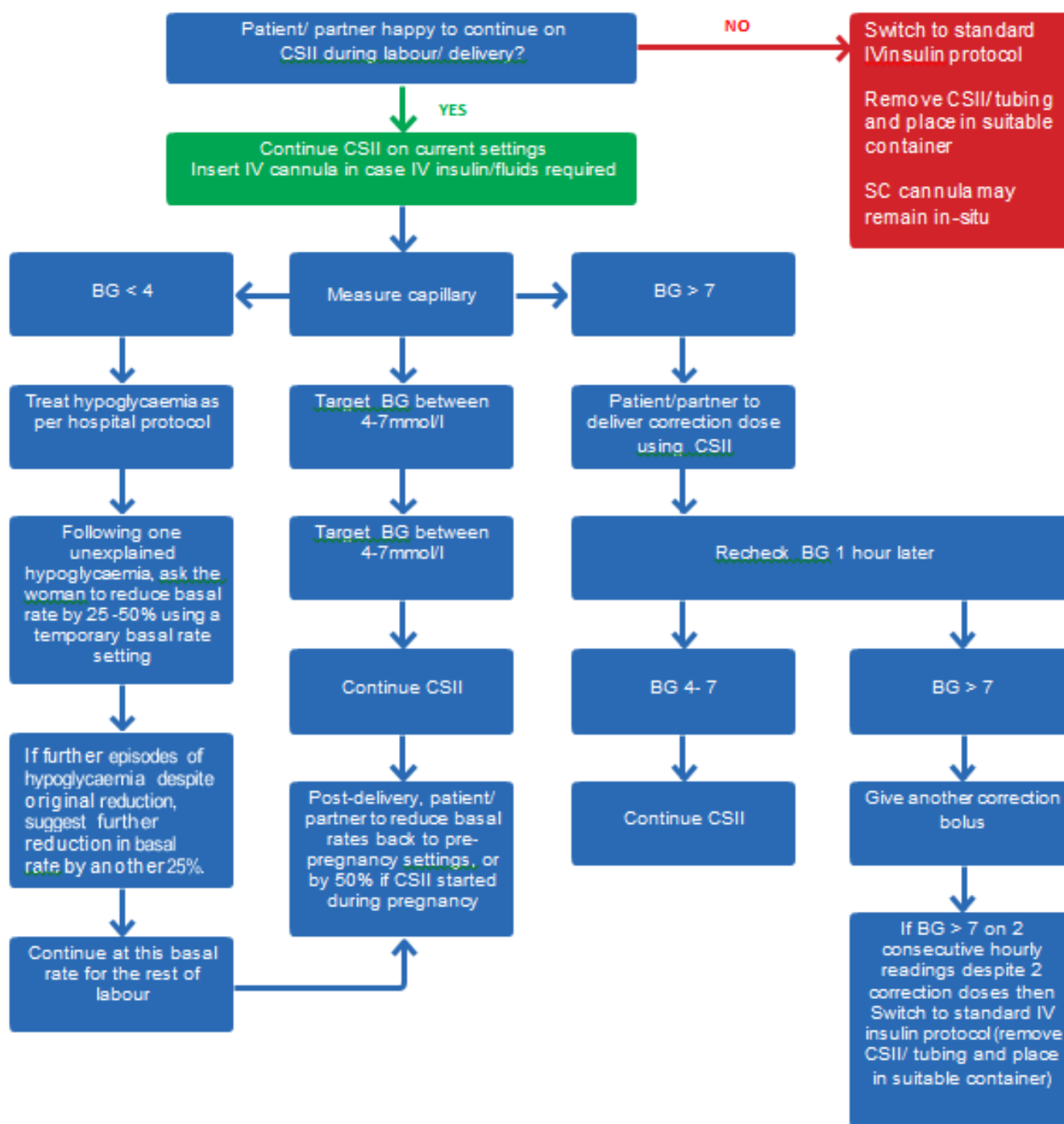
**TYPE 1 DM and INSULIN TREATED TYPE 2 DM** Reduce the rate of VRIII by HALF once placenta is delivered.  
Contact diabetes team to review on-going insulin requirements

INTRAVENOUS INSULIN, CBG AND KETONES MONITORING RECORD SHEET												
<b>Guide:</b> Only use for patients on intravenous insulin regimen. Use different chart for patients on subcutaneous insulin. Make sure the patient's hands are clean.										Patient label		
<b>Patients with type 1 DM on insulin pumps should be referred to the Diabetes Specialist Team on SALUS.</b> <b>Maintain IV insulin infusion for 30 minutes after re-starting original insulin regime – IV insulin has a 5 minute half-life</b>												

Date	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00	10:00	11:00	12:00
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CBG												
Insulin rate												
Blood ketones												
Initials												

Authors: Dr Kate Evans, Mrs Emma Green.  
 May 2020. Review May 2023. File in care pathways.  
 HRSG number:

**Appendix 3: Insulin pump management during pregnancy and labour**



**Insulin pump use in pregnancy:**

**Please inform the Diabetes Specialist antenatal team of any pregnant woman using CSII therapy admitted to hospital.**

CSII may continue whilst in hospital providing the patient or partner is able to self-manage the CSII and perform the required blood monitoring.

***Inpatient use of steroids during pregnancy in women using CSII:***

Please inform the Diabetes Specialist antenatal team before (or as soon as possible after) steroids are started.

CSII may continue. The Diabetes Specialist antenatal team will instruct the patient regarding any change in CSII settings. A temporary increase in basal rate of 30% or more may be required, and needs to be individualised based on patient requirements

Patients will be responsible for the management of CSII and glucose testing.

Patients will be required to test their glucose levels 1-2 hourly; aim for levels of 4- 7.8mmol/L.

If glycaemic targets are not achieved, Midwifery or obstetric staff should contact a DSN or Diabetes Consultant. Consider commencing VRII (without IV glucose). This should be prescribed in advance where possible. Note: CSII may be continued alongside VRII in this situation.

***Managing glycaemic control through delivery in women with Type 1 Diabetes on CSII:***

Women on CSII may be converted to VRII plus glucose for delivery (traditional management). Woman who chose, may continue to use their CSII through delivery, provided their blood glucose levels are within the target range of 4 – 7 mmol/L and patient/partner able to manage their CSII. The decision regarding the patient's suitability to self-manage CSII through delivery will be made by the diabetes specialist antenatal team and documented in the patient's case sheets. The diabetes team will educate the woman and her partner, and provide written instructions, regarding cannula siting, guidelines for using CSII through delivery, and situations where CSII treatment may need to be discontinued and traditional management instigated with VRII plus IV glucose. The individualised VRII should be prescribed in advance.

***Staff responsibilities:***

While the woman remains on CSII, the patient and her partner are responsible for checking glucose hourly, giving corrections via CSII, adjusting basal rates and other pump settings as required including at delivery. The midwife is responsible for ensuring the patient/ partner remains able and willing to manage their CSII, that glucose is checked and documented hourly, and that if glucose is persistently (see below) above 7mmol/l, VRII plus IV glucose is started and the CSII stopped. Once the patient is on VRII plus glucose, the midwife is responsible for checking glucose hourly and adjusting VRII rates as prescribed.

***Protocol for managing glycaemic control through delivery using CSII: (see flow chart)***

Measure and record blood glucose levels hourly using approved hospital blood glucose meter. The patient should continue her usual basal infusion rates, aiming to keep blood glucose levels between 4 - 7mmol/L. Bolus correction doses should be made by the patient via CSII to maintain target blood glucose levels 4 to 7mmol/l.

If patient/partner unable to manage CSII, or if blood glucose >7mmol/l for >2 hours despite correction doses, switch from CSII to individualised VRII plus IV glucose. (Remove CSII and tubing and place in suitable container; no need to turn off CSII nor to remove SC cannula).

***Correction doses during labour:***

If blood glucose greater than 7mmol/l, a correction bolus dose should be given via CSII, aiming for a blood glucose of 5mmol/l, using the patient's personal correction factor (also known as "ISF" = insulin sensitivity factor) or if not known, calculate 1 unit of insulin to reduce blood glucose levels by 2.5mmol/l e.g. if blood glucose 10.0 mmol/l, give 2 units bolus. After 1 hour, if that correction bolus is ineffective i.e. blood glucose still above 7.0 mmol/l, another correction bolus dose should be given via CSII (using the same calculation advice as above). After a further ½ hour, if blood glucose levels still not below 7.0 mmol/l, then switch to VRII plus IV glucose as above.

***Hypoglycaemia during labour:***

If blood glucose < 4.0mmol/l, treat hypoglycaemia as per hospital policy. If the woman has one unexplained hypoglycaemic event, she should reduce her current basal rate by 25 - 50% using a temporary basal rate setting. If having further episodes of hypoglycaemia despite original reduction, she should reduce by another 25% or more as required. A lower basal rate is usually required throughout the rest of labour. After delivery, the basal rate should change to the post-delivery basal rate which should have been defined.

***Post-delivery:***

Planned post-delivery CSII settings should be determined towards the end of pregnancy, in conjunction with the diabetes team, and documented. The basal profile is typically the same as pre-pregnancy basal profile often with a 10-20% reduction, or if CSII started during pregnancy, 50% of pre-delivery basal rates. This post-delivery basal profile can be entered into the pump memory in advance. The planned post- delivery insulin: carbohydrate ratio, ISF and targets will need to be programmed after delivery but before the first bolus dose.

If there is no documentation of postpartum doses then the basal rate can be set to 0.5 units/hour, insulin: carbohydrate ratio 1:15g, insulin sensitivity factor 4mmol/L, and BG targets 6-8mmol/L. These should be reviewed and adjusted in conjunction with the diabetes specialist team before discharge.

If the women continues on CSII for delivery, the basal rate should be changed to the planned post-delivery basal rate immediately at delivery and the bolus calculator settings changed as soon as possible but before the first bolus dose.

If managed with VRII, CSII can be recommenced once the patient is able to self-manage the pump. Ensure all pump settings are changed to post-delivery settings as above. The VRII should continue for 60 minutes after restarting CSII.

For women who are breastfeeding, settings may need reducing by a further 10-20% or even more as feeding is established.

<p><b>Monitoring and Audit</b> <b>Auditable standards:</b></p> <p><b>Reports to:</b> Maternity Assurance Group – responsible for action plan and implementation of recommendations from audit</p> <p><b>Frequency of audit:</b> Annual</p> <p><b>Responsible person:</b></p>
<p><b>Cross references</b> Maternity Hand Held Notes, Hospital Records and Record Keeping:</p>
<p><b>References</b></p> <p><b>JBDS guidelines:</b> <a href="http://www.diabetologists-abcd.org.uk/JBDS/JBDS_Pregnancy_final_18082017.pdf">http://www.diabetologists-abcd.org.uk/JBDS/JBDS_Pregnancy_final_18082017.pdf</a></p> <p><b>NICE guidelines:</b> <a href="https://www.nice.org.uk/guidance/ng3">https://www.nice.org.uk/guidance/ng3</a></p>

<b>Author</b>	Kate Evans, Emma Green	
<b>Work Address</b>	Maternity Unit, Derriford Hospital, Plymouth, Devon, PL6 8DH	
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