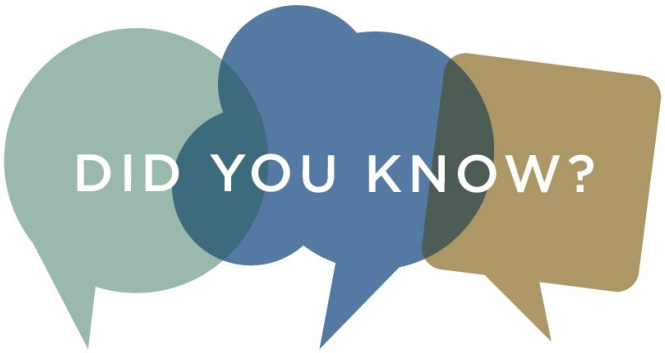
Alberta Health Services

Provincial Diabetes Inpatient Management Initiative
Diabetes, Obesity and Nutrition Strategic Clinical Network

KEY MESSAGES — In Hospital Diabetes Management



1. **1 in 5 of all adult patients admitted to hospital in Alberta has Diabetes**. Many of these patients, including those not on insulin at home, would benefit from insulin therapy in hospital.
2. In hospital glycemic targets are **5-10 mmol/L**
3. Hyperglycemia (blood glucose above 10 mmol/L) is common in hospital.
4. Hyperglycemia contributes to:
   - Delayed wound healing
   - Surgical site infections
   - Hospital acquired infections (such as pneumonia)
   - Increased length of stay
5. Hypoglycemia is often over treated.
   - 15 g of fast acting carbohydrate is usually adequate for treating most lows
   - Insulin doses should be reduced, rather than held, in most instances.
6. Insulin is a high alert medication frequently prescribed in acute care.
7. There is potential **harm** for the patient with sliding scale insulin. Sliding scale insulin (on its own) is a reactive approach, treating hyperglycemia after is has occurred.
8. There is improved patient **safety** with basal bolus insulin therapy (basal + bolus + correction insulin). Basal bolus insulin therapy decreases the number of hypoglycemic and hyperglycemic episodes for the patient.
9. **Patients with type 1 diabetes always need basal insulin.** *In other patients with diabetes, basal insulin should rarely be held.*
10. There are very few instances where all insulin doses should be held. *The **bolus** dose of insulin should be held if patient is not eating.*
11. Timing of insulin administration needs to be coordinated with blood sugar measurement and meals.
12. Inpatient glycemic management requires an interdisciplinary team approach, which includes the patient, with frequent communication between all team members.
13. Patients should be allowed and supported to self-manage their diabetes where appropriate.
14. Important aspects of supporting the patient's transition from, and back to, home are:
    - Ensure medication history done at admission, to confirm diabetes medications and dosage at home.
    - Include the patient in the ongoing diabetes management care plan.
    - The patient or caregiver needs to be aware of the discharge plan (written instructions); especially which diabetes medications are to be resumed, dose changes, and/or new medications added.
    - Provide communication to the community physician regarding course of care in hospital and discharge plan.

The DON SCN is leading a provincial initiative to enhance and improve inpatient diabetes management.

For more information about the initiative, please see a summary on our website at www.albertahealthservices.ca/10970.asp.