

BGSMC Critical Care Insulin Transition Protocol: Intravenous to Subcutaneous
(Do Not Use for Diabetic Ketoacidosis)

Patient Label

Note:	1. Do NOT discontinue IV insulin drip if patient is on vasoactive medications
Transition off of IV protocol Criteria	2. Please use this transition form for patients who meet below criteria: <ul style="list-style-type: none"> a. Known diabetes OR b. Admission Hgb A₁C > 6.5 OR c. Insulin drip is ≥ 1.5 units/hour (average) for the last 7 hours 3. If patient on tube feeding, initiate Tube Feeds: Subcutaneous Insulin Order Set with physician orders. See transition steps below. 4. If patient does not meet above criteria, initiate “Sliding Scale Insulin order set” See transition steps below.
Calculating Subcutaneous Dosing	5. Use Cerner Adhoc form “Critical Care Insulin Transition”. To calculate total daily dose use the last 7 insulin drip rates and omit the 2 highest insulin drip rates. Document the calculated doses in Final Dose section below. 6. If not using the Adhoc form, please refer to back of this form for dosing calculations. Once doses are calculated, document the doses in the section below (Summary of Final Doses).
Summary of Final Doses	Estimated Total Daily Dose (TDD) of Insulin _____ 7. _____ units glargine (Lantus®) subcutaneous q 24 hours at _____ <ul style="list-style-type: none"> • Give full dose even if NPO, on clear or full liquids or eating less than 50% of their meal. 8. _____ units rapid acting glulisine (Apidra®) insulin subcutaneous at the start of each meal <ul style="list-style-type: none"> • Administer within 30 minutes of start of meal. • Hold if NPO, on clear or full liquids or eating less than 50% of their meal.
Transition Steps	For patient transitioning to glargine (Lantus®) 9. Give initial glargine (Lantus®) dose 2 hours prior to discontinuing the drip 10. Check glucose with discontinuation of insulin infusion, then every 2 hrs x 2 (don’t treat these glucoses ≥ 70) 11. Start giving meal dose with next meal OR scheduled tube feed dose 4 hours after drip turned off For patient transitioning to sliding scale subcutaneous insulin only 12. Turn off drip 1 hours before next meal check glucose and treat according to below sliding scale 13. Check glucose before meal and treat according to Insulin sliding scale order set
Monitoring/ Supplemental Treatment	14. Blood glucose check before each meal and bedtime (2100) OR every 4 hours if patient is NPO 16. Check blood glucose at 2am if patient receives glulisine (Apidra®) at bedtime 17. Administer supplemental glulisine (Apidra®) per scale below along with schedule nutritional dose at meals 18. For the HS and 0200 am blood glucose (if checked), use the “Bedtime supplement scale”
HYPOGLYCEMIA: Blood Glucose < 70 mg/dl	19. Notify physician as soon as possible. 20. If conscious and able to swallow: 5 gram glucose tabs are the preferred treatment for patients that are eating. <input checked="" type="checkbox"/> For BG 50-69 mg/dl, give 15 grams oral carbohydrate <input checked="" type="checkbox"/> For BG < 50 mg/dl, give 30 grams oral carbohydrate <input checked="" type="checkbox"/> Repeat blood glucose check and treatment q 15 minutes until ≥ 70 mg/dL 21. If semi-conscious, unconscious, uncooperative, unable to swallow or is NPO: <input checked="" type="checkbox"/> Administer 50 ml of D ₅₀ W slow IV push OR if no IV access then Glucagon 1mg SubQ or IM and place IV 22. Once ≥ 70 mg/dL, repeat blood glucose check q 1hour X 3 to monitor for recurrence.

Glucose	Supplemental glulisine (Apidra®) scale: Use scale with daytime and q 4 hour blood glucoses					Bedtime Scale (2100 and 0200) –for ALL eating patients
	<input type="checkbox"/> BMI <25, non-diabetic, NPO or on Dialysis	<input type="checkbox"/> BMI 25-30	<input type="checkbox"/> BMI > 30	<input type="checkbox"/> OTHER	<input type="checkbox"/> Post OP CV Surgery	
<70	Follow Hypoglycemia Orders (above) AND Reduce Scheduled Dose of Apidra by 50%					
70-110 mg/dl	No change	No change	No change		No Change	No rapid insulin
111-130 mg/dl	No change	No change	No change		+1 units Apidra	No rapid insulin
131-150 mg/dl	No change	No change	No change		+2 units Apidra	No rapid insulin
151-175 mg/dl	+1 units Apidra	+2 units Apidra	+3 units Apidra		+3 units Apidra	No rapid insulin
176-200 mg/dl	+2 units Apidra	+3 units Apidra	+4 units Apidra		+4 units Apidra	1 units Apidra
201-225 mg/dl	+3 units Apidra	+4 units Apidra	+5 units Apidra		+5 units Apidra	2 units Apidra
226-250 mg/dl	+4 units Apidra	+5 units Apidra	+6 units Apidra		+6 units Apidra	3 units Apidra
251-300 mg/dl	+6 units Apidra	+7 units Apidra	+8 units Apidra		+8 units Apidra	4 units Apidra
301-350 mg/dl	+8 units Apidra	+9 units Apidra	+10 units Apidra		+10 units Apidra	5 units Apidra
351-400 mg/dl	+10 units Apidra	+11 units Apidra	+12 units Apidra		+12 units Apidra	6 units Apidra
≥ 401 mg/dl	+12 units Apidra	+13 units Apidra	+14 units Apidra		+14 units Apidra	7 units Apidra

Physician Signature: _____ **Date/Time** _____

<p>Calculating Doses</p> <p>(Also refer to physician dosing cards or pharmacy web site)</p>	<p>Calculate Estimated Total Daily Dose (TDD) of Insulin: To calculate total daily dose use the last 7 insulin drip rates and omit the 2 highest insulin drip rates. Document the calculated doses in Final Dose section below.</p> <ul style="list-style-type: none"> • Sum of the 5 lowest drip rates from the last 7 hours _____ X 4 = _____ (this is the TDD of insulin) <ol style="list-style-type: none"> 1. Basal insulin dose: <ul style="list-style-type: none"> • TDD divided by 2 = _____ units glargine (Lantus®) subcutaneous q 24 hours • Give Initial daily dose of Lantus dose subcutaneous 2 hours prior to stopping insulin drip, then every 24 hours at the same time each day. 2. Scheduled meal Apidra insulin: <ul style="list-style-type: none"> • Hold meal dose if they are NPO, on clear or full liquids, eating < 50% of meal • TDD divided by 6 = _____ units rapid acting Apidra Insulin subq at the start of each meal 3. Supplemental Apidra Sliding Scale orders: Administer supplemental Apidra along with schedule meal Apidra dose according to the appropriate scale (see front page of form)
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