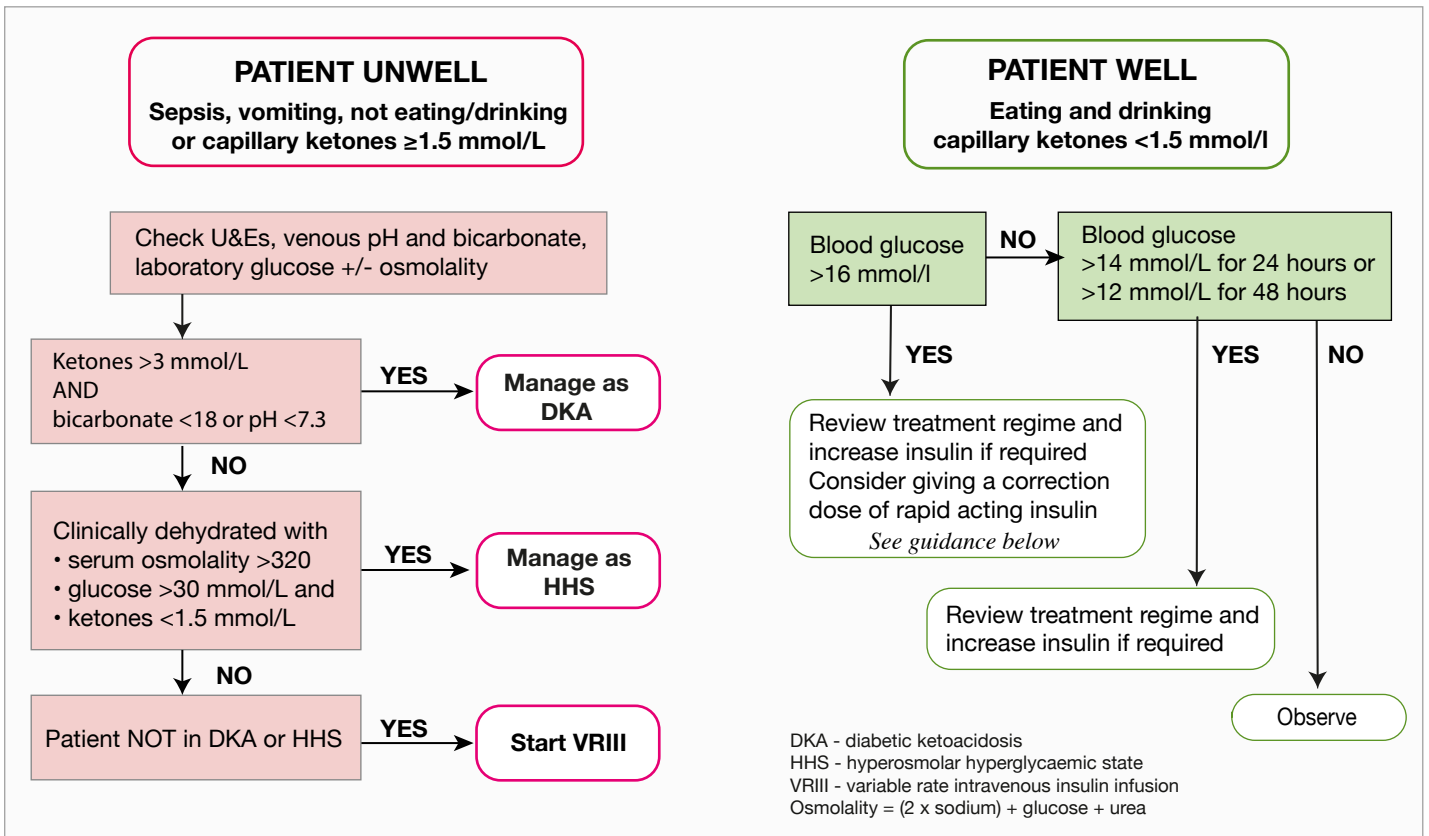


Management of Hyperglycaemia

- Check capillary ketones in any unwell patient with diabetes or in a well patient with diabetes where capillary blood glucose is >16 mmol/L (>11 mmol/L in pregnancy)
- If blood ketones measurements are unavailable, please contact your diabetes department
- Identify the cause of hyperglycaemia - check for intercurrent illness, missed or incorrect doses of insulin or hypoglycaemic agents, recent meal/snack, prescription of steroids or enteral feeding
- Ensure all patients requiring intravenous insulin or repeated correction doses of subcutaneous insulin are referred to the diabetes team at the earliest opportunity



Adapted from the University Hospital of Leicester NHS Trust

Guidance for use of correction doses of rapid acting insulin

- Do not give a correction dose without considering the underlying cause for hyperglycaemia and reviewing the patient's diabetes treatment
- Check capillary blood glucose at 2 and 4 hours after a correction dose
- Do not give correction doses more frequently than 4 hourly unless on the advice of the diabetes team
- Aim to correct the glucose level to 10 mmol/L unless an alternative target is specified
- Correction doses are usually based on a correction factor of 1:3 (i.e. 1 unit of rapid acting insulin reduces the blood glucose by 3 mmol/L)

Capillary blood glucose (mmol/L)	Typical correction dose (units)
18.1 - 25	4
>25	6

- The correction factor can be estimated using the 'rule of 100' and roughly equates to $100/\text{total daily insulin dose}$:
 - individuals on small doses of insulin may require lower correction doses to avoid hypoglycaemia e.g. slim individuals with Type 1 diabetes or those recently diagnosed
 - higher correction doses may be required in Type 2 diabetes where the total daily insulin dose is likely to be higher

This guidance is for clinical staff and it is not a substitute for clinical judgement or seeking advice from the inpatient diabetes team