Insulin Infusion Transition Prescribing Guideline (Non DKA/HHS)

Use when ceasing insulin infusion

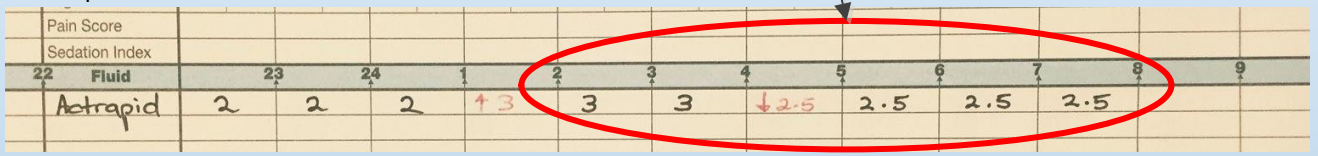
This is a guide and does not substitute for clinical judgement – consider the individual patient situation

Patient on IV Insulin infusion (non-DKA)

Does patient have:
- Type 1 DM
- Cystic Fibrosis

No → For all other patients:
1. Prescribe Supplemental Insulin (NovoRAPID®) pre-meals – *see **Table A***.
2. Monitor BGL QID (pre-meals) + 2am.
3. Add total insulin administered in preceding **6-hours** on infusion to get **calculated dose**.

example: 3 + 3 + 2.5 + 2.5 + 2.5 + 2.5 = 16 units



Is **calculated dose** more than 10 units?

No → 1. Stop insulin infusion
2. Ensure Supplemental insulin prescribed

Yes → 1. Prescribe **calculated dose** as Protaphane® bd (at least 8 hours apart). e.g. 16 units mane and 16 units nocte.
2. **Administer first dose 2 h before stopping IV insulin.**
3. Refer to Endocrine* for follow-up on ward.

→ Stop insulin infusion

Yes → Consult Endocrine* before stopping IV insulin

Table A

BGL (mmol/L)	Dose of supplemental insulin – tds pre meals		
	Insulin sensitive or NBM e.g. underweight elderly, haemodialysis	**Standard**	**Insulin-resistant** e.g. obese on >100 units /day
8.1 - 10	-	2 units	4 units
10.1 - 12	2 units	4 units	6 units
12.1 - 16	4 units	6 units	8 units
16.1 - 20	6 units	8 units	12 units
>20	8 units	12 units	16 units

To contact Endocrine*:
- Endocrine Registrar page 6810 or via switch Mon-Fri 08:00-17:00
- Endocrine Consultant on call via switchboard out of hours 24/7

Prepared by SVH Inpatient Diabetes Working Party July 2015 v11