

Attach ADR Sticker

ALLERGIES & ADVERSE DRUG REACTIONS (ADR)  
 Nil known  Unknown (tick appropriate box or complete details below)

Drug (or other)	Reaction/Date	Initials

FAMILY NAME **WILLIAMS** MRN **4786621**  
 GIVEN NAME **SIMON**  MALE  FEMALE  
 D.O.B. **21/02/41** M.O. **CROZIER**  
 ADDRESS **PREScription UNLESS IDENTIFIERS PRESENT**  
 LOCATION **HDU.**  
 COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

First Prescriber to Print Patient Name and Check Label Correct: Weight(kg):..... Height(cm):.....

Sign **Cor** Print **F.COX** Date **28/5**

**REGULAR SUBCUTANEOUS INSULIN**

Date	Type of Insulin <b>LANTUS</b> Frequency <b>NOCTE</b>				Type of Insulin <b>ACTRAPID</b> Frequency <b>TDS</b>				Type of Insulin			
	Pre B/Fast	Pre Lunch	Pre Dinner	Bed Time	Pre B/Fast	Pre Lunch	Pre Dinner	Bed Time	Pre B/Fast	Pre Lunch	Pre Dinner	Bed Time
28/5				30		10	20					
29/5				30	20	10	20					
30/5				30	20	10	20					
31/5				30	20	10	20					

**BLOOD GLUCOSE AND KETONE MONITORING**

BGL Frequency  Before meals  2 hours after meals  2200 hrs  
 (Tick box)  0200-0300 hrs  Other Specify: \_\_\_\_\_

Time	0200 - 0300 hrs	Breakfast		Lunch		Dinner		Bed Time 2200 hrs	Time	BGL	Action	Sign	Time	BGL	Action	Sign				
		Pre	Post	Pre	Post	Pre	Post													
			1000	1200		1800	2000													
BGL			12.6	9.2		13.1	8.7													
Ketones																				
		0730		1200	1400	1800	2000													
BGL		6.8		17.1	12.4	16.7	9.7													
Ketones																				
		0730	8.1	1200	1400	1800	2000	2200	0730	3.1	1000	13.7	10.7	23.4	14.2	10.3	0730	3.1	LMCOZADE	AT
BGL		0730	8.1	13.7	10.7	23.4	14.2	10.3	0730	3.1	1000	13.7	10.7	23.4	14.2	10.3	0730	3.1	LMCOZADE	AT
Ketones						0.4														
		0730	12.7	1200	1400	1800	2000													
BGL		0730	12.7	19.2	18.7	19.6	21.3	19.3	0730	2.9	1000	19.2	18.7	19.6	21.3	19.3	0730	2.9	LMCOZADE	R4
Ketones							0.8													

**SUPPLEMENTAL ORDER** To be used in addition to patient's usual diabetes treatment. See guidelines page 4

Type of Insulin **ACTRAPID** Contact \_\_\_\_\_

Signature Prescriber (Print name) **JOHNSTONE** Date **28/5**

Administration Times:  
 Before meals or  Specify: \_\_\_\_\_  
 If BGL range: **10-12** Give **2** units  
 If BGL range: **12-14** Give **4** units  
 If BGL range: **14-16** Give **6** units  
 If BGL range: **16-18** Give **8** units  
 If BGL range: **18-20** Give **10** units  
 If BGL range: \_\_\_\_\_ Give \_\_\_\_\_ units  
 If BGL range: \_\_\_\_\_ Give \_\_\_\_\_ units  
 Notify MO if BGL **7.20** mmol/L

Record of Administration														
Date	28/5		29/5		30/5		31/5		Date		Date		Date	
Dose given	Time/given by	Dose given	Time/given by	Dose given	Time/given by	Dose given	Time/given by	Dose given	Time/given by	Dose given	Time/given by	Dose given	Time/given by	
4	18:00 TD MY	8	12:00 AT KF	4	12:00 AT KF	10	12:00 RH PL							
		8	18:00 TD MY			10	18:00 LS JH							

**ONCE ONLY ORDER**

Date	Type of Insulin	Dose	Date/Time of dose	Prescriber			Administration		
				Print Name	Signature	Contact	Date	Time Given	Given by
28/5	ACTRAPID	4 Units	1000 28.5.18	F.COX	Cor		28.5.18	1005	TG RC
30/5	ACTRAPID	12 Units	1800 30.5.18	JOHNSTONE	J		30.5.18	1810	TD MY

**TELEPHONE ORDERS (to be signed within 24 hours of order)**

Date	Time	Type of Insulin	Dose	Nurse Initials Nr 1/Nr 2	Prescriber			Administration			
					Print Name	Signature	Contact	Date	Date/Time Given	Given by	

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Holes Punched as per AS2828.1: 2012 BINDING MARGIN - NO WRITING

Facility/Service: .....  
Ward/Unit: .....

**ALERTS**

Nil  
 Notify doctor \_\_\_\_\_ if; \_\_\_\_\_  
 OR  
 BGL less than \_\_\_\_\_ mmol/L OR BGL greater than \_\_\_\_\_ mmol/L  
 OR  
 Blood ketones greater than \_\_\_\_\_ mmol/L  
 OR  
 Urine ketones \_\_\_\_\_  
 Prescriber Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

Reason for nurse not administering insulin Codes MUST be circled	
Absent	(A)
Fasting	(F)
Refused-notify Dr	(R)
Vomiting-notify Dr	(V)
On Leave	(L)
Not Available - obtain supply or contact doctor and generate incident report	(N)
Withheld-Enter reason in clinical record	(W)
Self Administering	(S)

ADULT SUBCUTANEOUS INSULIN PRESCRIBING CHART SMR130035

**Instructions for Using Prescribing Chart**

- All Insulin prescription orders except intravenous (IV) infusions are to be recorded on this chart.
- Patients receiving subcutaneous insulin are to have their Blood Glucose (BGL) and ketones recorded on this chart.
- Specify the frequency of BGL monitoring (page 3). Tick as appropriate. Patients with unstable BGLs require more frequent monitoring.
- All patient management must also be documented in the patients health care records.

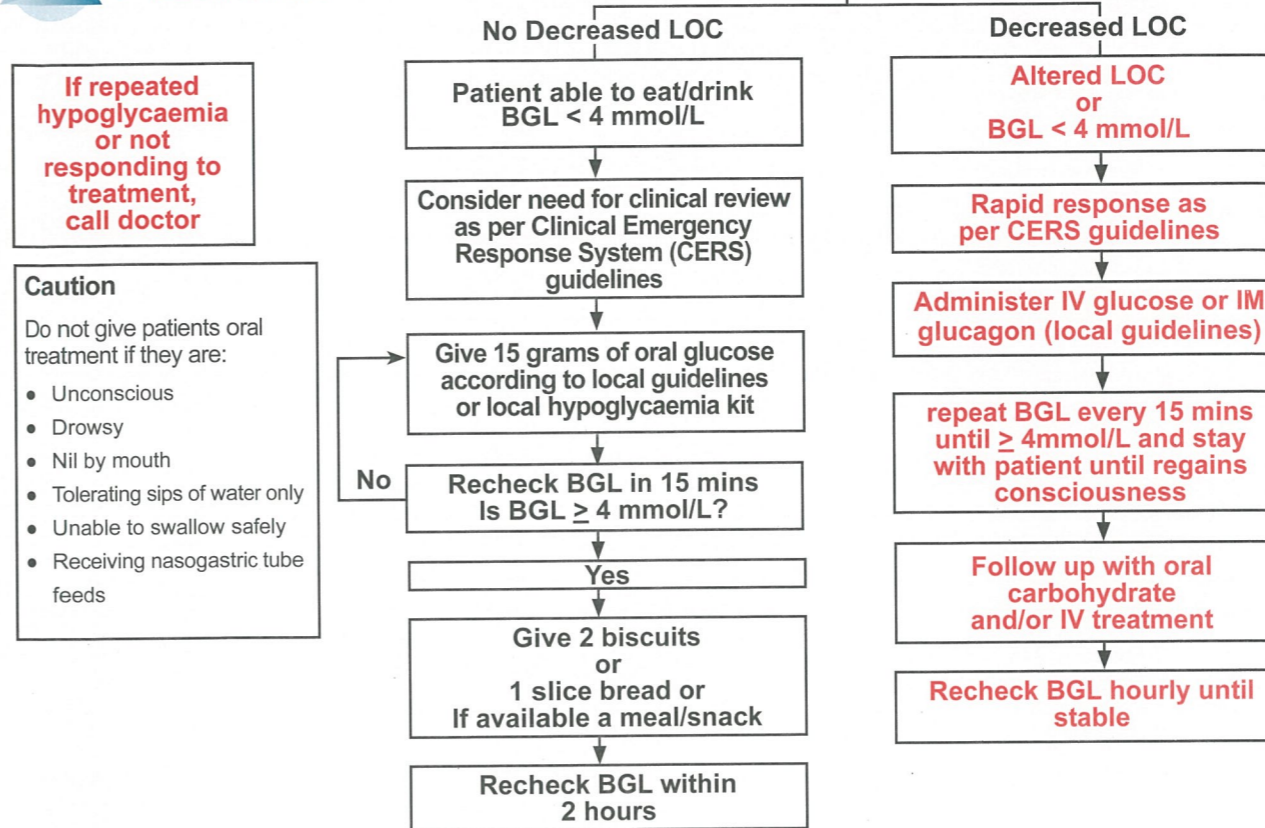
**Guide to Insulin Prescription and Administration**

- Daily review and prescribing of insulin is recommended as requirements can often vary whilst in hospital. Insulin may be prescribed in advance if the patient's glycaemic status is stable.
- Insulin requirements should be modified peri-operatively or when dietary intake is modified.
- For most patients the target BGL range is 5-10mmol/L, pregnancy is an exception.
- The word units has been pre-printed. Write the value only. **Do not re write the word units.**
- If any changes are to be made to the order - (eg. insulin type or dose), a completely new order is to be written. No alteration should be made to the original order.
- To discontinue an insulin order, the prescriber will draw two oblique lines in the administration column on the day of discontinuation of the drug and sign and date it. A single oblique line will also be drawn through the insulin name.
- The preferred site of insulin injection is the abdomen.
  - Insulin pump - (prescribe insulin on this chart. Write "insulin pump" below prescription)
  - Other diabetes medication on National Medication Chart

**Special Instructions**

DATE	INSTRUCTIONS	NAME (DESIGNATION)	SIGNATURE

**Guidelines Hypoglycaemia Management**



- Identify and treat the case of hypoglycaemia and document in health care records
- If the patient is hypoglycaemic when the next dose of insulin is due, delay administration until after correction of the hypoglycaemia. **Do not omit insulin**, consider dose review.

**Hyperglycaemia Management**

- Identify and treat the cause of hyperglycaemia.
- Review the appropriateness of the current insulin regimen and adjust doses as necessary (requirements may change as the patient recovers and mobilises).
- Consider commencement of an insulin infusion if the patient is NBM, vomiting or if hyperglycaemia persists, (according to local policy).
- Check BGL and ketones according to local policy.

**Supplemental Insulin and Correction of Hyperglycaemia**

- The patient's usual diabetes treatment, particularly insulin requirements, should be reviewed at least daily in the acute phase of their illness and adjusted as appropriate.
- Supplemental insulin is not a replacement for regular antihyperglycaemia therapy and should not be used in isolation.
- Supplemental insulin is best given before a meal, in addition to the patient's usual insulin doses, in order to prevent post meal hyperglycaemia.
- When prescribing supplemental insulin, state (1) the BGL range for each dose of insulin (2) the timing and frequency of administration. It is preferable to use the insulin analogues, aspart (NovoRapid), lispro (Humalog) or glulisine (Apidra) due to their more rapid onset and shorter duration of action.
- The following supplemental order may be used as a guide, however may need individual modification:

If BGL range before meals is:	10-12 mmol/L -----	Give 2 units of rapid acting insulin
	12.1-18 mmol/L -----	Give 4 units of rapid acting insulin
	18.1-20 mmol/L -----	Give 6 units of rapid acting insulin
	>20 mmol/L -----	Call for clinical review

The dose is determined by the current BGL and the patient's insulin sensitivity or weight.

- Multiple doses of supplemental insulin given within a short time frame (e.g. less than every 4 hours) may have an additive effect and result in hypoglycaemia.
- If significant hyperglycaemia persists, consider an insulin infusion (according to local policy).



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