The following insulin inflation protocol is intended for use in hyperglycemic adult patients in an ICU setting, but is not specifically tailored for those individuals with diabetic emergencies, such as diabetic ketoacidosis (DKA) or hyperglycemic hyperosmolar states (HHS). When these diagnoses are being considered, or if BGs 500 mg/dL, an MD should be consulted for specific orders. Also, please notify an MD if the response to the insulin inflation is unassed or unexpected, or if any situation arises that is not adequately addressed by these guidelines.

#### Initiating an Insulin Infusion

L) INSULIN INFUSION: Mix 1 U Regular Human Insulin per 1 oc 0.9 % NaCl. Administer via infusion pump (in increments of 0.5 U/hr).

2.) PRIMING: Flush 50 cc of infusion through all IV tubing before infusion begins (to saturate the insulin binding sites in the tubing).

3.) TARGET BLOOD GLUCOSE (BG) LEVELS: 100-139 mg/dL

4.) BOLUS & INITIAL INSULIN INFUSION RATE: Divide initial BG level by 100, then round to nearest 0.5 U for bolus AND initial infusion rate. Examples: 1.) Initial BG = 325 mg/dL: 325 + 100 = 3.25, round † to 3.5: IV bolus 3.5 U + start infusion @ 3.5 U/hr.

2.) Initial BG = 174 mg/dL: 174 = 100 = 1.74, round 1 to 1.5: IV bolus 1.5 U + start infusion (ii) 1.5 U/hr.

#### Blood Glucose (BG) Monitoring

1.) Check BG hourly until stable (3 consecutive values within target range). In hypotensive patients, capillary blood glucose (i.e., fingersticks) may be inaccurate and obtaining the blood sample from an indwelling vascular catheter is acceptable.

2.) Then check BG q 2 hours; once stable x 12-24 hours. BG checks can then be spaced to q 4 hours IF:

a.) no significant change in clinical condition AND b.) no significant change in nutritional intake.

 If any of the following occur, consider the temporary resumption of hourly BG monitoring, until BG is again stable (2-3 consecutive BG values within target range):

a.) any change in insulin infusion rate (i.e., BO out of target range)

b.) significant changes in clinical condition

c.) initiation or cessation of pressor or steroid therapy

d.) initiation or cessation of renal replacement therapy (hemodialysis, CVVH, etc.)

e.) initiation, cessation, or rate change of nutritional support (TPN, PPN, tube feedings, etc.)

BG 75-99 medd. BG 100-139 medd. BG 140-199 medd.

#### Changing the Insulin Infusion Rate

If BG < 50 mg/dL: D/C INSULIN INFUSION

Give I amp (25 g) D50 IV; recheck BG q 15 minutes.

-- When BG at 100 mg/dL, wait 1 hour, then restart insulin infinion at 50% of original rate.

If BG 50-74 mg/dt.:

DAC INSULIN INFUSION If gamptomatic (or unable to assess), give 1 amp (25 g) D50 IV; recheck BG q 15 minutes.

If asymptomatic, give 1/2 Amp (12.5 g) D50 IV or 8 ounces juice; recheck BG q 15-30 minutes.

-- When BG a 100 mg/dL, wait I hour, then restart infusion at 75% of original rate.

If BiG is 75 mg/df.

STEP 1: Determine the CURRENT BG LEVEL - identifies a COLUMN in the table:

STEP 2: Determine the <u>RATH OF CHANGE</u> from the prior BG level - identifies a <u>CELL</u> in the table - Then move right for INSTRUCTIONS: (Note: If the last BG was measured 2-d hrs before the current BG, calculate the <u>hopoly</u> rate of sharge. Example - 15 mg/sit. 30 mg/sit. 30 mg/sit. and the BG at 4PM is now 120 mg/sit. the total change over 2 hours is -30 mg/sit.) the hours of change is -30 mg/sit. 2 hours = -15 mg/sit. 30 mg/sit.

BG 75-99 mg/dL	BG 100-139 mg/dL	BG 140-199 mg/dL	BG a 200 mg/dL	INSTRUCTIONS*
		BG † by > 50 mg/dL/hr	BG †	† INFUSION by "2A"
	BG † by > 25 mg/dL/hr	BG † by 1-50 mg/dL/hr or BG UNCHANGED	BG UNCHANGED OR BG   by 1-25 mg/dL/hr	† INFUSION by "A"
BG †	BG 1 by 1-25 mg/dL/br, BG UNCHANGED, OR BG 1 by 1-25 mg/dL/br	BG   by 1-50 mg/dL/hr	BG   by 26-75 mg/dL/hr	NO INFUSION CHANGE
BG UNCHANGED OR BG   by 1-25 mg/dL/hr	BG   by 26-50 mg/dL/hr	BG 4 by 51-75 mg/dL/br	BG ‡ by 76-100 mg/dL/br	; INFUSION by "A"
BG   by > 25 mg/dL/hr	BG   by > 50 mg/dL/hr	BG ‡ by > 75 mg/dL/hr	BG ‡ by > 100 mg/dL/hr	HOLD x 30 min, then   INFUSION by "2A"

DVC INSULIN INFUSION; vBG q 30 min; when BG a 100 mg/Li, central minimizer (g) 75% of most record rate.

\*CHANGES IN INFUSION RATE ("A") are determined by the current rate:

Current Rate (U/hr)	A = Rate Change (Ufbr)	2A = 2X Rate Change (Whr)
< 3.0	0.5	1
3.0 - 6.0	1	2
6.5 - 9.5	1.5	3
10 - 14.5	2	- 4
15 - 19.5	3	6
20 - 24 5	4	8
≥ 25	a 5	10 (consult MD)

# **Yale Insulin Protocol**

**Celia Levesque** 

#### **Yale Insulin Protocol:**

Insulin in Clinical Practice Mr. Rohit Manglik, 2024-05-24 Offers a clinical guide to insulin therapy in diabetes care Covers initiation titration and special population considerations Management of Diabetes Mellitus Diana Guthrie, Richard Guthrie, 2008-10-22 I strongly recommend this text Whether the reader is a relative novice or a seasoned veteran in diabetes care the information will prove useful and concise and will likely stimulate further reading and study House staff planning to rotate on my endocrine service should be forewarned Management of Diabetes Mellitus A Guide to Pattern Management is now required reading JAMA Praise for the previous edition I recommend this book to nurses or physicians confronting patients afflicted with diabetes mellitus as it presents a patterned approach to the understanding and management of this malady Any patient with diabetes mellitus or health care professional using the information presented by these experts would be well prepared to manage this disease process Gloria K Twilley Lieutenant Colonel United States Air Force Nurse Corps The sixth edition of Management of Diabetes Mellitus fully reorganizes and expands upon the previous editions While the new edition continues to set forth practical and easy to use guidelines for management the newly expanded chapters contain detailed information on managing patients with different types of diabetes type 1 and type 2 and further differentiates treatment and management strategies for various age groups This edition also offers clear and concise explanations of the disease process newly revised guidelines for the use of complementary and alternative therapies and a guide for developing an educational program Guthrie and Guthrie also stress the importance of self management of diabetes as much of this edition is dedicated to educating the diabetic patient on how to provide self care and control both acute and chronic complications of the disease For the convenience of practitioners and diabetic patients themselves this book contains reproducible forms protocols and guides that can be used for managing diabetes including Nutrition guestionnaires Meal patterns comparing exchanges Carb Counting and Calorie Points Sample Calorie Point Distributions Exercise Log Intake Assessment Guide Clinical Practice Recommendations A guide to the pattern approach Textbook of Critical Care Nutrition Subhal Bhalchandra Dixit, Kapil Gangadhar Zirpe, Atul Prabhakar Kulkarni, 2023-11-17 Cardiothoracic Critical Care Brigid Flynn, Natalia S. Ivascu, Vivek K. Moitra, Alan Gaffney, 2020-11-06 This text focuses on cardiothoracic critical care and covers guidelines for evidence based practice respiratory and metabolic physiology common hemodynamic perturbations ventricular failure and mechanical circulatory support devices All clinicians who care for cardiothoracic patients who are critically ill can find pearls of practice wisdom complemented by literature citations within this text Diabetes, An Issue of Critical Care Nursing Clinics Celia Levesque, 2013-03-28 This issue of Critical Care Nursing Clinics Guest Edited by Celia Levesque RN MSN NP C CNS BC CDE BC ADM from MD Anderson will focus on Diabetes Article topics will include Management of Diabetes in the Clinical Setting Hyperglycemia management after solid organ transplantation Insulin therapy in the hospitalized patient Limb salvage for Vetrans with diabetes and Management of steroid induced hyperglycemia in the

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