Screening for Diagnosis of Diabetes:
To test for diabetes or to assess risk of future diabetes, either Hemoglobin A1C, Fasting Plasma Glucose (FGP), or 2-
75 g Oral Glucose Tolerance test (OGTT) are appropriate.
An A1C level of 5.7% to 6.4% indicates increased risk for diabetes (pre-
diabetes).

The criteria for the diagnosis of diabetes (indicated by one of the following):
1. A1C level of 6.5% or higher
2. FPG level of > 126 mg/dL
3. Two hour OGTT level of > 200 mg/dL

Prevention/delay of type 2 diabetes: refer to support program targeting weight loss of 7% of body weight and physical activity at least 150 min/week (i.e. Diabetes Prevention Program).

In those identified with prediabetes, identify, and if appropriate, treat other CVD risks.

http://care.diabetesjournals.org/content/42/Supplement_1/S1

The PDF file of these guidelines is available at http://education.musc.edu/dsc

South Carolina Adult Guidelines for Diabetes Care in the Hospital – 2019

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<td>Diabetes Type: type 1, type 2, suspect type 1, suspect type 2, CF related diabetes, gestational, pre-diabetes or other (drug or stress induced)</td>
<td>Order A1C on all patients with diabetes or hyperglycemia (blood glucose &gt;140mg/dL) if not able to document level in MR within 90 days of admission (excluding gestational) and/or prior to elective surgery to assess glycemic control.</td>
<td>Written protocols or orders for WBG POC testing to include frequency and individual plan for subsequent monitoring. WBG POC testing results should be available to all members of the health care team. WBG POC testing policy should include limitations of WBG POC testing in critically ill patients defined by the institution (i.e., hypothermia, anasarca, pressors, etc.).</td>
<td>a. Diet orders should be based on body weight and comorbidities (NPO, PO, Enteral and Parenteral Nutrition) b. Consistent carbohydrate should be provided or added to other diet orders c. Written policy/protocol for the coordination of WBG POC testing, insulin administration and meal tray delivery d. Nutrition consult ordered, if indicated</td>
<td>Insulin therapy should be initiated per written orders sets. Insulin therapy is the preferred method during hospitalization. In critical care units, validated protocols for IV infusion is the preferred route of insulin administration with goals for blood glucose levels of 140-180mg/dL. More stringent goals such as 110 -140mg/dL may be appropriate in select patients. In non-critically ill patients, scheduled subcutaneous insulin with basal, nutritional and correctional components is the preferred method with a goal of 140-180mg/dL. a. Basal insulin: to control glucose between meals and suppress overnight hepatic glucose production (NPH, glargine, detemir, U-500) b. Prandial/nutritional insulin: to cover carbohydrate load from meals or enteral nutrition - give as rapid acting insulin analog with meals (aspart, lispro, glulisine) c. Correction insulin (give as rapid acting insulin analog): to correct pre-meal hyperglycemia d. The sole use of sliding scale insulin is discouraged.</td>
<td>Written policy, protocol and/or order set for treatment of hypoglycemia. Hypoglycemia is defined as a blood glucose (BG) &lt; 70 mg/dL; clinically significant &lt;54 mg/dL; severe as altered mental and physical status requiring assistance. Written nurse driven protocols and order sets to include: a. Treatment for hypoglycemia and a plan for prevention of hypoglycemia for each patient b. Recheck of WBG POC test within 30 minutes of the first WBG POC test &lt; 70mg/dL c. Adjustment of anti-hyperglycemic regimen, if applicable</td>
<td>Written protocols and order sets to include: a. Fluid replacement b. Correct electrolytes c. Low dose insulin therapy d. Hourly BG testing when patient is receiving IV Insulin infusion e. Policy for transitioning from IV Insulin Infusion to subcutaneous insulin regimen (i.e., basal insulin given 2 hours prior to discontinuing IV Insulin Infusion)</td>
<td>Standardized written policies, protocols and order sets are recommended to integrate components of care, preserve the necessary complexity of management of diabetes, standardize order entry, protect the safety of the patient, facilitate patient individualization, and permit patient self-management, where appropriate. This includes: a. WBG POC Testing b. Hemoglobin A1C c. Consistent carbohydrate diet d. Hypoglycemia protocol e. Insulin Order Set: Basal, prandial/nutritional and correction f. IV Insulin Infusion, transition from IV Insulin Infusion to subcutaneous insulin administration and transition to home regimen prior to discharge g. Continuous Subcutaneous Insulin Infusion Pump Therapy (CSII)</td>
<td>The following groups have education specific to policies, protocols, order sets and patient management related to diabetes: dietitians, dietary staff, staff involved in WBG POC testing, medical staff, nursing staff including advanced practice, pharmacists, physician assistants and interdisciplinary team.</td>
<td>Preparing the patient for discharge should include: Medication reconciliation including an explanation of medication changes, pending tests and studies with patient and caregivers Diabetes education (medication, nutrition, exercise, hypoglycemia, BG monitoring, sick day guidelines, discharge and contact information) Document in MR a diabetes follow-up appointment after hospital discharge and other provider appointments, if applicable Referral to ADA recognized or AADE accredited Diabetes Self-Management Education and Support (DSMES) Program if applicable</td>
<td>Written protocols and order sets are recommended for the following patients with diabetes: a. Perioperative and pre-procedural b. Gestational</td>
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Adopted: March 6, 2015