Guidelines for Diabetes Care in the Hospital, Nursing Home, and Skilled Nursing Facility 2015

Recommendations

Diabetes discharge planning should start at hospital admission, and clear diabetes management instructions should be provided at discharge. **E**

The sole use of sliding scale insulin (SSI) in the inpatient hospital setting is strongly discouraged. **A**

All patients with diabetes admitted to the hospital should have their diabetes type clearly identified in the medical record. **E**

Critically Patients

Insulin therapy should be initiated for treatment of persistent hyperglycemia starting at a threshold of no greater than 180 mg/dL (10 mmol/L). Once insulin therapy is started, a glucose range of 140–180 mg/dL (7.8–10 mmol/L) is recommended for the majority of critically ill patients. **A**

More stringent goals, such as 110–140 mg/dL (6.1–7.8 mmol/L), may be appropriate for selected patients, as long as this can be achieved without significant hypoglycemia. **C**

Critically ill patients require an intravenous insulin protocol that has demonstrated efficacy and safety in achieving the desired glucose range without increasing risk for severe hypoglycemia. **E**

Non-critically Patients
If treated with insulin, generally premeal blood glucose targets of <140 mg/dL (7.8 mmol/L) with random blood glucose <180 mg/dL (10.0 mmol/L) are reasonable, provided these targets can be safely achieved. More stringent targets may be appropriate in stable patients with previous tight glycemic control. Less stringent targets may be appropriate in those with severe comorbidities. **C**
A basal plus correction insulin regimen is the preferred treatment for patients with poor oral intake or who are taking nothing by mouth (NPO). An insulin regimen with basal, nutritional, and correction components is the preferred treatment for patients with good nutritional intake. **A**
A hypoglycemia management protocol should be adopted and implemented by each hospital or hospital system. A plan for preventing and treating hypoglycemia should be established for each patient. Episodes of hypoglycemia in the hospital should be documented in the medical record and tracked. **E**
Consider obtaining an A1C in patients with diabetes admitted to the hospital if the result of testing in the previous 3 months is not available. **E**
Consider obtaining an A1C in patients with risk factors for undiagnosed diabetes who exhibit hyperglycemia in the hospital. **E**
Patients with hyperglycemia in the hospital who do not have a prior diagnosis of diabetes should have appropriate follow-up testing and care documented at discharge. **E**