



Doncaster and Bassetlaw
Teaching Hospitals
NHS Foundation Trust

In Hospital Management of Hypoglycaemia in Adults with Diabetes Mellitus, to include Non Diabetes Hypoglycaemia algorithm.

This procedural document supersedes any previous guidelines in relation to this subject: PAT/T 49 v.4 - In Hospital Management of Hypoglycaemia in Adults with Diabetes Mellitus



Did you print this document yourself?

The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

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Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 5	7 November 2023	<p>The major changes are updated.</p> <p>The amount of intravenous glucose administered has been specified throughout.</p> <p>The guidance throughout refers to people and persons with diabetes instead of in-patients to align with Language matters.</p> <p>Advice for the threshold for hypoglycaemia remains at less than 4.0mmol/L, for people with diabetes in hospital.</p> <p>Where vulnerable patients are involved who may be on Sulphonylureas (Gliclazide) or insulin therapy. Levels between 4.0 - 6.0mmol/L could indicate looming hypoglycaemia.</p> <p>Page 5: An individual plan of care should be agreed between the clinician and the diabetes team.</p> <p>Page 7: new updated algorithm.</p> <p>The guide refers to people or persons where possible instead of in-patients to align with 'language matters'</p> <p>Page 15: non diabetes hypoglycaemia guide added.</p>	Shivani Dewan/Andre Oprescuj/Sue Robson
Version 4	2 July 2020	<p>Page 6 Amend to 2 tubes of Glucose Gel Amend treatment may need repeating after 15 minutes if no improvement.</p> <p>Page 7, 3rd heading, spelling mistake for patient</p> <p>Page 8 Remove 45-60mls Fort juice and leave 60mls Fort juice</p> <p>Page 12 Document has been revised Jan 2020, accessed 05/05/2020</p> <p>Page 14 Appendix 2. See attached minor changes to form, now filed in patient notes and not faxed to diabetes center.</p> <p>Page 15 - Date changes</p> <p>Minor Changes to document.</p>	S Dewan/ S Robson

Version 3	14 July 2017	Changes made to definition of fast acting carbohydrate. Please do not use Lucozade to treat hypoglycaemia	S Dewan/ S Robson
Version 2	November 2013	Document reviewed and redesigned Appendix 2 added	S Dewan
Version 1	November 2010	This is a new procedural document, please read in full	S Dewan

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1. INTRODUCTION

With the increasing prevalence of diabetes in the community, there has been an increase in diabetes in hospitalised persons. Most of these are treated with insulin or an oral agent that can cause Hypoglycaemia. Approximately one in four people with diabetes suffer a Hypoglycaemic episode during their hospital stay. Inpatient Hypoglycaemia not only increases length of stay but is also associated with an increase in mortality.

Prevention of Hypoglycaemia and its prompt and effective treatment is therefore essential. This guideline gives comprehensive advice on the management of Hypoglycaemia in a variety of clinical situations from fully conscious, to the conscious but confused and through to the unconscious person.

This guideline directs clinical staff to identify those at risk of Hypoglycaemia or those progressing into a Hypoglycaemic event and the subsequent treatment, observations and escalation. Staff involved in providing diabetic care to their patients should be aware of individualised blood glucose levels and how these should be adjusted to suit the person's clinical circumstances under the direction of the (Diabetes Specialist Nursing) DSN team or clinician.

2. PURPOSE

Prevention of people suffering Hypoglycaemia during their in-patient admission whilst improving their diabetes control, reduced complications and improve care and clinical outcomes. Any person identified with looming Hypoglycaemia. Blood glucose levels should be personalised to suit their circumstances.

3. DUTIES AND RESPONSIBILITIES

This guideline is designed to be Nurse-led. All nurses must work within the Nursing and Midwifery Council (NMC) professional code of conduct and work within their own competencies.

Diabetes hospital team

- Implementation of this policy and all National recommendations made regarding diabetes and Hypoglycaemia.
- Ensure education and training of all appropriate Trust staff.
- Responsibilities to ensure all persons with diabetes receive an equitable and high quality service.
- To be alerted to all persons with diabetes who are identified having episodes of Hypoglycaemia via the electronic database.

Escalate any incidents regarding diabetes management to the relevant clinical governance groups.

Consultant Diabetologist and Lead Nurse

Act as a clinical expert in diabetes management. Provide education and training to all staff.

Divisional Head of Nursing

Support the Lead Nurse in provision of care for people with Diabetes

Matrons and Ward Managers

To promote safe standards of diabetes care on all wards as appropriate. Ward Managers to release staff when required in order to participate in education and training

All staff directly involved in caring for people who have potential and are experiencing episodes of Hypoglycaemia

All staff to attend/undertake relevant training to provide safe effective care when dealing with people having episodes of Hypoglycaemia. To ensure all people with Diabetes are referred to the Diabetes Specialist Nurse Team so that they can offer the people and staff full support and guidance. Episodes of Hypoglycaemia.

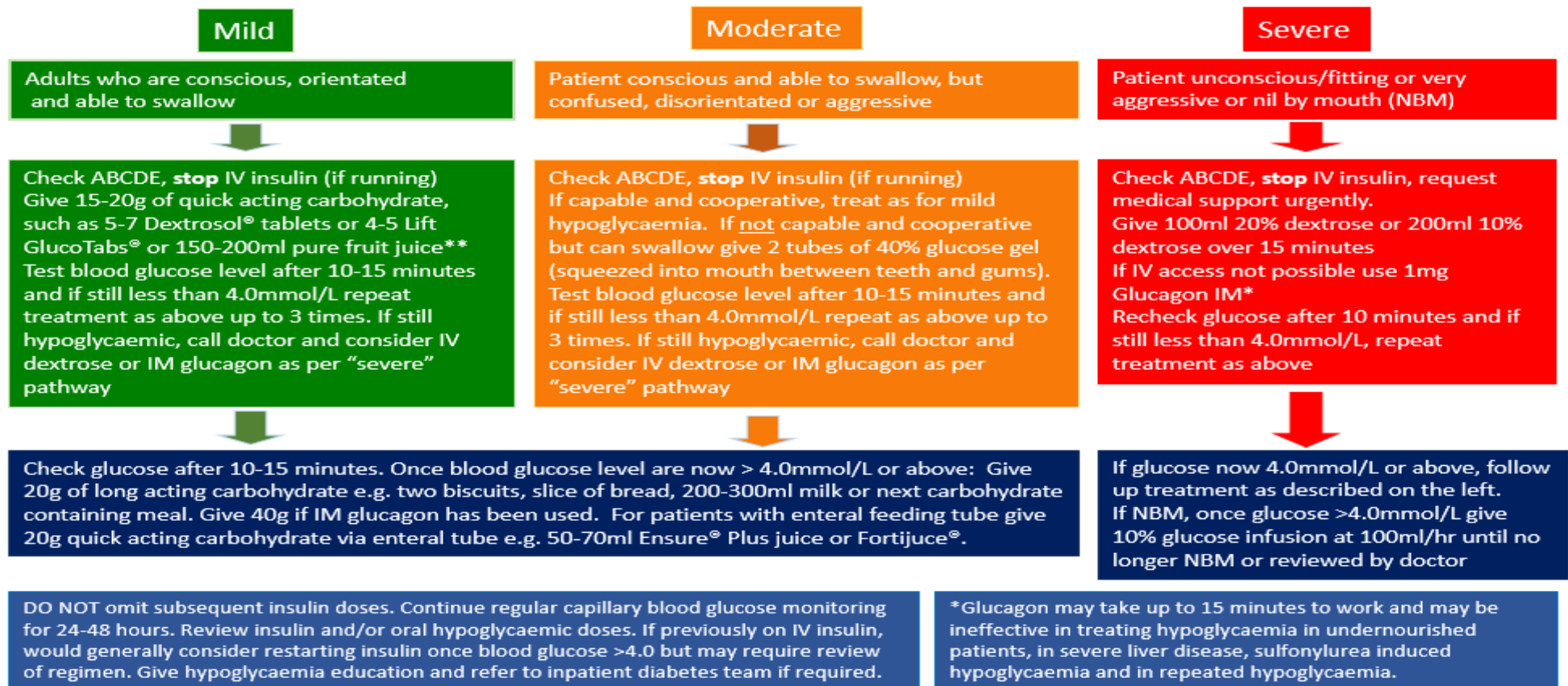
4. PROCEDURE

Algorithm for the Management of Hypoglycaemia in Adults with Diabetes in Hospital

Hypoglycaemia is a serious condition and should be treated as an emergency regardless of level of consciousness

Hypoglycaemia is defined as blood glucose of $<4.0\text{mmol/L}$ (if not $<4.0\text{mmol/L}$ but symptomatic give a small carbohydrate snack for symptom relief)

See full guideline "The Hospital Management of Hypoglycaemia in Adults with Diabetes Mellitus" at www.diabetes.org.uk/joint-british-diabetes-society



PRACTICAL CONSIDERATIONS

FOR TABLET CONTROLLED PATIENTS WITH A BLOOD GLUCOSE LESS THAN 4.0MMOL/L

Give 15-20g quick acting carbohydrate of the person's choice where possible. Once blood glucose is above 4.0mmol/L and the person has recovered, give a long acting carbohydrate.

If blood glucose level remains less than 4.0mmol/L after 45 minutes (or 3 cycles of treatment) **Contact a doctor**. Consider IV 10% glucose infusion at 800ml/hr500ml bag. Or 20% glucose infusion at 400ml/hr 100ml vial. Volume should be determined by clinical circumstances. Consider smallest volume in renal and cardiac failure.

Ensure regular capillary blood glucose monitoring is continued for 24 to 48 hours. Give hypoglycaemia education or refer to Diabetes Inpatient Specialist Nurse (DISN)

Refer to flow chart and follow step A

FOR INSULIN CONTROLLED PATIENTS WITH A BLOOD GLUCOSE LESS THAN 4.0 MMOL/L

DO NOT omit insulin injection if due (However, dose review may be required). Give half the usual dose.

Give 15-20g quick acting carbohydrate of the person's choice where possible. Once blood glucose is above 4.0mmol/L and the person has recovered, give a long acting carbohydrate.

If blood glucose level remains less than 4.0mmol/L after 45 minutes (or 3 cycles of treatment) **Contact a doctor**. Consider IV 10% glucose infusion at 800ml/hr100ml bag. Or 20% glucose infusion at 400ml/hr 100ml vial. Volume should be determined by clinical circumstances. Consider smallest volume in renal and cardiac failure.

Ensure regular capillary blood glucose monitoring is continued for 24 to 48 hours. Give Hypoglycaemia education or refer to Diabetes Inpatient Specialist Nurse (DISN)

Refer to flow chart and follow step A

IF A PERSON IS ON IV INSULIN WITH A BLOOD GLUCOSE LESS THAN 4.0 MMOL/L

If the person has an insulin infusion in situ, **stop immediately**.

Give 15-20g quick acting carbohydrate of the person's choice where possible. Once blood glucose is above 4.0mmol/L and the person has recovered, give a long acting carbohydrate.

If the person is on IV insulin, only restart after a review of dose regimen, continue to check blood glucose every hour.

Ensure regular capillary blood glucose monitoring is continued for 24 to 48 hours. Give hypoglycaemia education or refer to Diabetes Inpatient Specialist Nurse (DISN).

Refer to flow chart and follow step A

PEOPLE WHO SELF MANAGE THEIR INSULIN PUMPS WITH A BLOOD GLUCOSE LESS THAN 4.0 MMOL/L

Give 15-20g quick acting carbohydrate of the person's choice where possible. 7-10g quick acting carbohydrate for pump patients on Hybrid closed loop.

People who self-manage their insulin pumps may not need a long acting carbohydrate

Ensure regular capillary blood glucose monitoring is continued for 24 to 48 hours. Give hypoglycaemia education or refer to Diabetes Specialist Nurse (DSN.)

Refer to flow chart and follow step A

PEOPLE WHO ARE 'NIL BY MOUTH' WITH A BLOOD GLUCOSE OF LESS THAN 4.0 MMOL/L

If the person has a variable rate intravenous insulin infusion, adjust as per prescribed regimen, and seek medical advice. Once blood glucose is greater than 4.0mmol/L and the person has recovered consider 10% glucose at a rate of 100ml/hr. until patient is no longer 'Nil by Mouth' or has been reviewed by a doctor.

Ensure regular capillary blood glucose monitoring is continued for 24 to 48 hours. Give Hypoglycaemia education or refer to Diabetes Specialist Nurse (DSN)

Refer to flow chart and follow step B and C

PEOPLE REQUIRING ENTERAL FEEDING WITH A BLOOD GLUCOSE LESS THAN 4.0MMOL/L

People requiring total parenteral/enteral nutrition (TPN or feeds) should be referred to a dietitian /nutrition team and diabetes team for individual assessment.

Do not administer these treatments via a TPN line.

Give 15-20g quick acting carbohydrate of the patient's choice where possible.

Some examples are:

25ml original undiluted Ribena®

50-70 mls Fort juice

3-4 heaped teaspoons of sugar dissolved in water

All treatments should be followed by a water flush of the feeding tube to prevent tube blockage. Once blood glucose is above 4.0mmol/L and the patient has recovered, restart feed. If bolus feeding, give additional bolus feed (read nutritional information and calculate amount required to give 20g of carbohydrate). Alternatively, give 10% IV glucose at 100ml/hr. Volume should be determined by clinical circumstances.

Ensure regular capillary blood glucose monitoring is continued for 24 to 48 hours. Give Hypoglycaemia education or refer to Diabetes Specialist Nurse (DSN)

Refer to flow chart follow step B and C

WHEN HYPOGLYCAEMIA HAS BEEN TREATED SUCCESSFULLY

Identify the risk factor or cause resulting in Hypoglycaemia. Take measures to avoid Hypoglycaemia in the future. The DSN or diabetes team can be contacted to discuss this.

Please **DO NOT** omit next insulin injection or start variable rate intravenous insulin infusion to 'stabilise' blood glucose.

Please **DO NOT** treat isolated spikes of Hyperglycaemia with 'stat' doses of short/rapid acting insulin. Instead, maintain regular capillary blood glucose monitoring and adjust normal Insulin regimen if a

particular pattern emerges.

COMPLETE HYPOGLYCAEMIA AUDIT FORM (See Appendix 3)

Any hypo caused by 'care issues' must complete a DATIX

ADMISSION FROM A&E IS LIKELY TO BE REQUIRED IN:-

- The elderly
- The socially isolated
- People on long acting Sulphonylureas i.e. Glibenclamide, Chlorpropramide, Gliclazide Sustained Release.
- People with prolonged Hypoglycaemia where recovery is incomplete.
- People who have taken a deliberate insulin or oral Hypoglycaemic overdose.
- People with co-existing medical conditions needing further investigation.

ALL PEOPLE ADMITTED WITH HYPOGLYCAEMIA WILL NEED REFERRAL TO THE DIABETES IN- PATIENT TEAM.

GENERALISED POINTS FOR CONSIDERATION

- **Hypoglycaemia may last up to 72 hours**
- Referral to the Health Care Professional responsible for the person's diabetes care (i.e. General Practitioner if discharged, or secondary care diabetes team). This may be useful for those with a poor understanding of their diabetes.
- Hypoglycaemia may be fatal in elderly patients taking Sulphonylureas.
- Hypoglycaemia may be precipitated by worsening renal function, hepatic failure or heart failure
- People who take Acabose need treatment with intravenous/oral glucose and not sucrose.
(A fast acting carbohydrate drink or glucose tablets can be given to patients taking Acarbose.)

- **CONSIDER CAUSE OF HYPOGLYCAEMIA AND MAKE POSSIBLE CHANGES TO PREVENT A SIMILAR OCCURRENCE.**
1. Reinforce education to those experiencing hypoglycaemia
 2. Blood glucose levels may remain high after initial treatment therefore; avoid making incremental adjustment to insulin dose in the ensuing 24 hours.

HYPOGLYCAEMIA IN THE NON-DIABETIC PATIENT IN HOSPITAL

- Hypoglycaemia in non-diabetic people requires investigations and a referral to the physician with an interest in Diabetes/ Endocrinology. This should be carried out to identify the cause. (see appendix 3).

PEOPLE LACKING CAPACITY

Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances staff must treat the person in accordance with the Mental Capacity Act 2005 (MCA 2005).

- A person lacking capacity should not be treated in a manner which can be seen as discriminatory.
- Any act done for, or any decision made on behalf of the person who lacks capacity must be done, or made, in their Best Interest.
- Further information can be found in the MCA policy, and the Code of Practice, both available on the intranet/extranet.

There is no single definition of Best Interest. Best Interest is *determined on an individual basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision should be in the Best interest of the individual. Please see S5 of the MCA code of practice for further information.*

5. TRAINING/ SUPPORT

Each member of staff is accountable for his/her practice and should act in such a way to promote safety and well-being. Each staff member will receive instructions and direction regarding hypo prevention and control information from a number of sources.

- Trust policies and procedures available on the intranet
- Link Nurse to provide ward based education and keep a register of all training sessions.
- Group/individual educational sessions provided by the In-patient Diabetes Specialist Nurses.
- Virtual college/E Learning/self- directed
- Educational displays/posters (hypo awareness week)

Training sessions for Hypoglycaemia treatment and use of the hypo box will be provided by the link nurse at ward level, by the nurse educators and the in-patient Diabetes Specialist Nurses.

6. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

Audit of this policy will be as per the National Guidelines- <http://www.diabetologists-abcd.org.uk/JBDS/JBDS.htm>. This would be done annually by the Ward Manager to look at the ease and effectiveness of the hypoglycaemia treatment guidelines, treatment regimens followed.

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Cause of hypoglycaemia identified & recorded.	The Diabetes Nursing Team	3 Monthly	Hypoglycaemia audit forms to be reviewed by DSNs/diabetes team. If hypo forms not received, to DATIX as incident. The audits are to include information identified from UNIPOC.
Time to recovery	The Diabetes Nursing Team	3 Monthly	Hypoglycaemia audit forms to be reviewed by DSNs/diabetes team
Percentage of appropriate insulin/anti-hyperglycaemic medication dose adjustment	The Diabetes Nursing Team	3 Monthly	Hypoglycaemia audit forms / JAC to be reviewed by DSNs/diabetes team

7. DEFINITIONS

Hypoglycaemia is defined as a finger prick or laboratory glucose level of less than 4.0 mmols/L.

8. EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Equality Diversity and Inclusion Policy (CORP/EMP 59).

The purpose of the EIA is to minimize and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 3).

9. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

- PAT/MM 1 A – Safe and Secure Handling of MEDICINES POLICY Part A
- PAT / T33 - Physiological observations and prevention of deterioration in the acutely ill adult
- Guide lines for intravenous fluids/medication
- PAT/PA 19 - Mental Capacity Act 2005 Policy and Procedure, including Deprivation of Liberty Safeguards (DoLS)
- PAT/PA 28 - Privacy and Dignity Policy.
- Hypoglycaemia guidelines for non-diabetes patients.
- CORP/EMP 59 – Equality Diversity and Inclusion Policy
- CORP/EMP 27 – Equality Analysis Policy

10. DATA PROTECTION

Any personal data processing associated with this policy will be carried out under ‘Current data protection legislation’ as in the Data Protection Act 2018 and the General Data Protection Regulation (GDPR) 2016.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website.

11. REFERENCES

Joint British Diabetes Society (revised Jan 2020) The Hospital Management of Hypoglycaemia in Adults with Diabetes Mellitus [online] accessed on 05/05/2020 at [JBDS 01 Hypo Guideline with QR code January 2023.pdf](#)

Department of Constitutional Affairs Mental Capacity Act (2005): Code of Practice, 2007
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

APPENDIX 1 - GLUCAGON

GLUCAGON

Contraindication: Insulinoma, Glucagonoma, ineffective in chronic Hypoglycaemia, starvation and adrenal insufficiency.

Glucagon not to be given in case of Reactive Hypoglycaemia, in patients without diabetes.

APPENDIX 2- NON DIABETES HYPOGLYCAEMIA GUIDE

Treatment of Acute Hypoglycaemia of Any Cause in a Hospital Environment

A Doncaster and Bassetlaw Teaching Hospitals Guideline

Hypoglycaemia of any cause is a potentially life-threatening medical emergency and requires immediate recognition and treatment.

Definition:

Hypoglycaemia is defined as a syndrome present when the blood glucose level falls below the normal fasting glucose range, which in general is below 4.0. Please be aware, that at levels below the normal range, the most common blood glucose meters or glucose monitors such as Freestyle Libre may not be accurate.

Aetiology:

Most common cause is iatrogenic or factitious hypoglycaemia in those with access to glucose-lowering drugs-which include people with diabetes, most common insulin, sulfonylurea, Meglitinide, but also aspirin, fluoroquinolones, quinine, haloperidol, disopyramide, beta-blockers, tramadol, proton pump inhibitors, and heparin.

Endocrine causes such as adrenal insufficiency and growth hormone deficiency (both most often in children), Hypopituitarism, Hyperthyroidism, Hypothyroidism, Tumours (neuroendocrine such as Insulinomas, IGF-II secreting tumours), insulin receptor abnormalities. Hyperinsulinaemic Hypoglycaemia in non-diabetic patients is very rare (the incidence of insulinoma is estimated to be 0.4 per 100000 person-years and more rare in paediatric patients).

Toxins (alcohol-use disorder-worse when associated with starvation, Ackee fruit-hypoglycin).

Gastric surgery People may present with early reactive Hypoglycaemia: gastric bypass, Vagotomy with Pyloroplasty, subtotal or total gastrectomy.

Neonatal (nesidioblastosis also called persistent hyperinsulinemia of infancy, islet hypertrophy, newborn of a diabetic mother). Premature Infants or infants with a low birth weight have a higher incidence of Hypoglycaemia than full-time infants with a weight appropriate for gestation age. Congenital such as glycogen storage disorders.

Other Causes: early pregnancy (late reactive Hypoglycaemia during pregnancy), advanced malnourishment (prolonged nutrition-deficient states, terminal cancer, dementia), acute or chronic liver disease, chronic renal failure, congestive heart failure, critical illness involving multi-organ failure, and sepsis.

Clinical Symptoms:

Those with a Diabetes diagnosis: may display only a few or **none** of these symptoms, due to impaired or lost Hypoglycaemia awareness, and they may rapidly progress/deteriorate.

Sympathoadrenal Symptoms (will usually begin when blood glucose falls below 3.0): sweating, anxiety, tremors, nausea, hunger, tingling, and palpitations.

Neuroglycopenic Symptoms (will usually begin when blood glucose falls below 2.8): dizziness, blurred vision, confusion, aggressive behavior, somnolence, dysarthria, seizures or focal neurological deficits (may look like a stroke.)

If not treated, these symptoms will progress to convulsions, coma and possible death.

The following symptoms should be present in cases of **true Hypoglycaemia** in **non-diabetes**-these are known as

Whipple's Triad

1. Hypoglycaemia symptoms
2. Accompanying low blood glucose concentration
3. Resolution of symptoms after raising the blood glucose level back to normal

Treatment of Hypoglycaemia in a Hospital Environment (AE, Wards)

Step1: Hypoglycaemia is suspected based on the above symptoms and confirmed to be less than 4.0 (i.e., bed-side finger prick glucose test)

Step 2A: If the patient is unconscious or not able/not safe to swallow, obtain immediate intravenous access and initiate an intravenous infusion of at least 200ml 10% Dextrose running over 10-15 minutes, or 100ml of 20% Dextrose running over 10-15 minutes. Repeat a bed-side blood glucose after 10-15 minutes.

Continue treatment with 10% Glucose at a speed of 100ml per hour (or faster if needed) until the blood sugars raises at least above 4mmol/l and remains stable in a safe range (such as 4- 10mmol/l).

Take a blood sample if safe to do so (if there is more than one person available to manage the patient, one can administer the treatment and the other can take the bloods and/or obtain intravenous access), but do not delay treatment! Please send the following when the case history is unknown or unclear: lab glucose, insulin C-peptide, sulfonylurea levels, Hydroxybutyrate levels, cortisol, TSH, FT4, FBC, U/E, and LFT.

If unable to obtain intravenous access, give a 1mg intramuscular dose of Glucagon, while further attempts for intravenous access are being made. Glucagon will be ineffective in people whose liver glycogen is depleted, therefore should not be used in persons with prolonged fasting, adrenal insufficiency, chronic Hypoglycaemia or alcohol-induced Hypoglycaemia. It may also be less-effective in persons taking sulfonylurea. In these cases, intravenous glucose should be used.

Step 2B: If the person is conscious and able/safe to swallow, offer oral sugar-containing treatment, such as Hypo stop, Fort juice, glucose tablets, glucose gel, and orange juice. If necessary, repeat treatment after 15 minutes, up to 3 times, until blood glucose level raises above 4.0. Once the blood glucose raises above 4, give a complex meal, such as a snack or sandwich. Please note, meals containing both sugar and fat, such as chocolate, may be ineffective as will slow gastric emptying.

Step 3: Continuous monitoring of the blood glucose and continuous treatment with intravenous glucose is essential and may be life-saving for these people.

Depending on the Aetiology of the Hypoglycaemia (see below) some people might require ongoing treatment with intravenous glucose for hours and/or days. In suspected alcohol excess, thiamine supplementation should be given with, or immediately after the intravenous glucose, to minimise the risk of Wernicke's encephalopathy.

Step 4: Obtain and document a clear history and review medications. Consider a referral to the Medical team/registrar, Diabetologist or Endocrinologist as appropriate.

For all cases where the cause of Hypoglycaemia is not obvious, (i.e., non-Diabetic Hypoglycaemia).

Please refer to an Endocrinologist for further investigations and follow up in clinic.

APPENDIX 3 – HYPOGLYCAEMIA AUDIT FORM

IPOC 1486
WPR 40823
Apr 2020
WHITE

NHS
Doncaster and Bassetlaw
Teaching Hospitals
NHS Foundation Trust

HYPOGLYCAEMIA AUDIT
PROFORMA

AFFIX LABEL HERE IF AVAILABLE

NHS Number:
District Number:
Surname:
Forename(s):
Address:
.....
D.o.B:

To be completed by a Healthcare Professional after each hypoglycaemic episode.

Ward: Consultant:

Date of event: / / Time of event: : (24 hour clock)

Hypoglycaemia episode type - please insert letter from key below:

Key:

- A** Patient was conscious, orientated and able to swallow
- B** Patient was conscious but confused, disorientated, aggressive or had an unsteady gait but was able to swallow
- C** Patient was unconscious and/or having seizures and/or was very aggressive
- D** Patient was conscious, orientated but 'Nil by Mouth'
- E** Patient requiring enteral feeding

Treatment Administered

Blood Glucose (BG) at time of event:
BG - 15 mins after treatment
BG - 15 mins after treatment (if required)

Was Hypoglycaemic Treatment Guideline followed? Yes No - If 'No', please give details:

.....
.....
.....

Did the patient self-manage? Yes No Patient recovered? Yes No If 'No', please give details:

.....
.....
.....

What steps were taken to identify the reason for the hypoglycaemia? (Please give details)

.....
.....
.....

Print name: Signature:

Designation: Date: Time:

Form to be placed in front of medical notes and filed on discharge.

APPENDIX 4 – EQUALITY IMPACT ASSESSMENT - PART 1 INITIAL SCREENING

Service/Function/Policy/Project/Strategy	Division/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
In Hospital Management of Hypoglycaemia in Adults with Diabetes Mellitus – PAT/T 49 v.4	Department of Diabetes and Endocrinology. Division of Medicine	Annette Johnson	Existing Policy	May 2023
1) Who is responsible for this policy? Name of Care Group/Directorate: Division of Medicine				
2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? Patients-appropriate treatment of in-hospital hypoglycaemia				
3) Are there any associated objectives? Legislation, targets national expectation, standards				
4) What factors contribute or detract from achieving intended outcomes? Education of nursing staff				
5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, Maternity/pregnancy and religion/belief? No				
If yes, please describe current or planned activities to address the impact [e.g. Monitoring, consultation]				
6) Is there any scope for new measures which would promote equality? [any actions to be taken]				
7) Are any of the following groups adversely affected by the policy? NO				
Protected Characteristics	Affected?	Impact		
a) Age	No			
b) Disability	No			
c) Gender	No			
d) Gender Reassignment	No			
e) Marriage/Civil Partnership	No			
f) Maternity/Pregnancy	No			
g) Race	No			
h) Religion/Belief	No			
i) Sexual Orientation	No			
8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box				
Outcome 1	✓	Outcome 2	Outcome 3	Outcome 4
Date for next review: September 2027				
Checked by: Sue Robson			Date: May 2023	