Chart: 1 2 3 of 1 2 3 (circle) Site: Lister QE2 (circle) MVCC

East and North Hertfordshire NHS NHS Trust

Adult Medication Prescription and Monitoring Record for Patients with Diabetes (Inpatient Drug Chart)

Patient Name:

Address:

Date of Birth:

ADDRESSOGRAPH

NHS No:

Hospital No:

Date of Admission:	**Ward**	**Ward Transfer**	**Ward Transfer**	**Consultant**
Weight (kg):				
Height (cm)	**Female patients only:** Pregnant ☐ Breast feeding ☐			**Renal function:** Known CKD ☐ AKI ☐
BMI/BSA				

DRUG SENSITIVITIES / ALLERGIES / ADVERSE DRUG REACTIONS - PLEASE STATE IF NO KNOWN DRUG ALLERGIES
This section must be completed before prescription/administration except in exceptional circumstances

Drug/substance	Description of allergy/reaction	Completed by (sign & designation)	Date

ONCE ONLY DRUGS (including pre-medication, loading doses and once daily gentamicin)
Please document the reason for prescribing all stat doses in the notes to aid in patient management

Date	Time	Drug	Dose	Route	Signature and contact detail	Administered			Pharmacy
						Date	Time	Initials	

Gentamicin monitoring: **Take sample immediately before next due dose.** For once daily dosing trough should be <1mg/ml	Date	Date	Date
	Level	Level	Level

Pharmaceutical care information

Drug history confirmed (Name, date and contact)		Nil reg meds ☐	Source of drug history: Pt PODs GP MAR Other.....
PODs brought in? Yes No POD's checked by	More at home? Yes No Repeat presciption? Yes No	Community pharm info	Rewritten drug chart checked (Name, date and contact)

DHx discrepancies reviewed by doctor (tick) ☐ Name/bleep _____/_____ Date _____

Other information/comments/discrepancies (e.g. reason for drug(s) stopped or under review with reason, medication changes)

New meds counselling	Purpose and how to take ☐	Side effects ☐	Written info, further help ☐	Inhaler counselling ☐
TTO details	Nutritional supplements on TTO Yes No RD initials/date	TTO screened by, time and date:		Completed on ward ☐ Sent to pharmacy ☐

ENH00256

Venous Thromboembolism (VTE) Risk Assessment for ADULT patients

(Pregnant patients; use separate Obstetrics VTE risk assessment: MVCC see below)

All adult patients must: 1) have their mobility status assessed. 2) be risk assessed, and where appropriate be prescribed appropriate thromboprophylaxis. 3) Be re-assessed appropriately during their stay as per guidance.

Step 1: MOBILITY – all patients Tick one box			
	Day Case Procedures considered very low risk of VTE eg Haemodialysis, Endoscopy, Chemotherapy. All local anaesthetic procedures. All regional/sedation procedures that **do not** involve immobilisation of lower limb	☐	Risk assessment now complete Go to step 5
	SURGICAL or **Medical** patients acutely admitted to wards	☐	Assess for thrombosis and bleeding risk Complete steps 2,3,4 and 5

Step 2: THROMBOSIS RISK (tick all that apply and score 1 for each risk factor)

Patient related risk factors	Assessment Stage 1	2	3	4	New onset (admission related) or transient risk factors	Assessment Stage 1	2	3	4
Active cancer or cancer treatment					Significantly reduced mobility for 3 days or more				
Age > 60					Hip or knee replacement				
Dehydration					Hip fracture				
Known thrombophilia					Surgery plus anaesthetic time > 90mins				
Personal history or first-degree relative with a history of VTE					Surgery involving pelvis or lower limb with a total anaesthetic plus surgical time > 60mins				
One or more significant medical comorbidities e.g.heart disease (acute MI within 3 months), metabolic, endocrine or respiratory pathologies; acute infectious diseases; nephrotic syndrome; active inflammatory conditions					Acute surgical admission with inflammatory or intra-abdominal condition				
Obesity (BMI >30kg/m^2)					Critical illness requiring admission to ICU/CCU/HDU				
Use of hormone replacement therapy					Surgery with significant reduction in mobility				
< 6 weeks post partum; parity >4					**Mount Vernon Hospital Cancer Centre** the following do not require VTE assessment or prophylaxis: 1) Ambulant patients on multiple daily chemotherapy 2) Patients on a clinical trial until clarification on day 1 post-admission 3) Patients being treated with antiangiogenic drugs e.g sunitinib Go to step 5				
Use of oestrogen-containing contraceptive therapy									
Varicose veins with associated phlebitis									

Step 3: BLEEDING RISK (tick all that apply and score 1 for each risk factor)

Patient related risk factors	Assessment Stage 1	2	3	4	New onset (admission related) or transient risk factors	Assessment Stage 1	2	3	4
Active bleeding					Neurosurgery, spinal surgery or eye surgery				
Acquired bleeding disorder (such as liver failure)					Other procedures with high bleeding risk				
On therapeutic anticoagulant (e.g. dabigatran, rivaroxaban or warfarin with INR >2)					Lumbar puncture/ epidural/ spinal anaesthesia expected within the next 12 hours				
Acute stroke					Lumbar puncture/ epidural/ spinal anaesthesia within the previous 4 hours				
Thrombocytopenia (platelets <75x10^9/L)									
Uncontrolled systolic hypertension (≥ 230/120mmHg)									
Untreated inherited bleeding disorders (such as haemophilia or von Willebrands disease)									

CONTRAINDICATIONS to DALTEPARIN					CONTRAINDICATIONS to TEDS				
Previous HIT or allergy to LMWH					Severe peripheral vascular disease; severe dermatitis/ulceration of leg; leg oedema; gross leg deformity; peripheral neuropathy; recent skin graft				
Creatinine >150micromol/L (CrCl <30ml/min): Use Dalteparin 2500 inits once daily									
Urea >30mmol/L: avoid unless very high risk or monitor by antiXa assay.									

Step 4: action to be taken once risk assessed (tick which applies to patient)

Thrombosis risk score	Bleeding risk score	Intervention	Stage1 on admission	Reassessment Stage 2	Stage 3	Stage 4
0	0	**None needed:** consider impulse or compression device or TED stockings in surgical patients				
≥ 1	0	**Prescribe** Dalteparin and TED stockings if appropriate				
≥ 1	**≥ 1**	**Hold** Dalteparin and review bleeding risk				

Step 5: Assessment complete

VTE risk assessed by: **POA / on admission** (circle)	**Sign/print:**	Bleep: /contact	Date:

Month / Year | Patient Name: | NHS No / Hospital No:

VTE reassessment - using the tool on page 2	**VTE Stage**	**VTE risk assessed by:**		
For POA patients this should be completed on admission. Reassess all patients whenever clinical situation changes and formally as follows: Surgical patients 24 hrs post op and then every 7 days Medical patients every 7 days Obstetrics patients every 24 hrs	Stage 2	Sign/print:	Bleep:	Date:
	Stage 3	Sign/print:	Bleep:	Date:
	Stage 4	Sign/print:	Bleep:	Date:

Patient unable to receive LMWH prophylaxis (dalteparin) due to contraindication or on treatment dose of any other anticoagulant. ☐	**Signature: Contact details/date**

DALTEPARIN S/C PROPHYLAXIS		Date	
Dose (circle or insert) **2500 units 5000 units**	**Start Date**	18:00	
Sign /print / contact	Change of dose date	Standard dose: 5000 units od Renal dose: 2500 units od (Cr >150micromol/L, eGFR <30ml/min) and in patients <50kg NB Do not administer to dialysis patients on their dialysis days **Pregnancy: based on patients weight** - refer to Trust guidelines	
	Pharm		

First choice for mechanical prophylaxis is TEDS			**Nursing staff – date/sign check appropriate fitting/working**
TEDS	Sign	Date:	
Flowtrons	Sign	Date:	

DALTEPARIN S/C TREATMENT		Date	
Dose (insert) **units**	**Start date**	18:00	
Sign/print/contact	Pharm	For initial treatment of VTE see tables below (for extended treatment >30 days refer to SPC) Pregnancy and treatment of ACS refer to Trust Guidelines and prescribe in main body of chart	

Dalteparin treatment dose for VTE in patients with normal renal function

Patient weight (Kg)	<46	46 – 56	57 – 68	69 - 82	>83
Dose (units)	7,500	10,000	12,500	15,000	18,000

Dalteparin treatment dose for VTE in patients with impaired renal function

Patient weight (Kg)	<47	48 - 61	62 - 80	>80
eGFR 15-30 ml/min Dose (units)	5,000	6,500	8,000	10,000
eGFR <15ml/min Dose (units)	4,500	5,000	7,000	9,000

Tick box if patient receiving other parenteral anticoagulants or twice daily dalteparin ☐
(e.g. fondaparinux, unfractionated heparin, lepirudin, bivalirudin or danaparoid) These should be prescribed in the main body of the drug chart

ORAL ANTICOAGULANTS

Vitamin K antagonists e.g. warfarin, acenocoumarol (nicoumalone) and phenindione
Prescribers need to ensure INR checked at appropriatei intervals and dose prescribed accordingly

Admitted on anticoagulant ☐ | Commenced this admission ☐ | Anticoagulant book with patient ☐

Drug	Give at 18:00	Date	
INR target		INR	
Dose on admission		Dose	
Indication / Duration		Sig	
Pharmacy / Counselled ☐		Given by	

New oral anticoagulants e.g. dabigatran, rivaroxaban, apixaban
Prescribers must determine whether once or twice daily dosing and circle times as appropriate.

Admitted on anticoagulant ☐ | Commenced this admission ☐ | Alert card with patient ☐

Drug	Date	
Dose / Frequenecy (circle) Nocte bd	06:00	
Sign/print/contact	18:00	

Date	Indication	Duration	Pharmacy / Counselled ☐

Month / Year Patient Name: NHS No / Hospital No:

Codes for drugs prescribed but not administered

When a drug is not given at the appropriate time record the appropriate number on the chart.
Every effort must be made to ensure medication is given as prescribed. If the reason is not readily identifiable then a record must be made in the nursing notes. **In all cases if the medicine is included in the Critical Drugs List (i.e. the list of medicines that must not be omitted or delayed) the ward pharmacist should be contacted during opening hours. Outside these times contact the duty matron or night manager to arrange supply. The prescribing team may need to be informed.**

1. Patient declined/refused
2. Patient away from ward
3. On instructions of doctor (record reason in nursing notes)
4. Medication not available
5. Patient nil by mouth: If it is a surgical patient refer to the Trust Peri-operative Policy as some drugs may need to be administered.
6. Patient nauseous and/or vomiting
7. Patient self administered (this must be under supervision, as such the nurse should also initial the box to indicate they observed the patient self administer the medication correctly)
8. Other reason. (document clearly in nursing notes)

Nursing staff: if a second check is required (e.g. all IV medicines, CDs), divide the signature box with a horizontal line to allow for two initials. Enter time administered if more than 60 minutes difference from the prescribed time.

REGULAR PRESCRIPTIONS

OXYGEN via nasal cannula unless specified

Circle target oxygen saturation

88-92% **94-98%** **Other:**

Starting device/ flow rate | Route

PRN or Continuous (refer to O2 guidelines)

Tick here if saturations are not indicated ☐

Sign/print/contact | Date

Date → | Time ↓ | Nurse: at each drug round initial box to confirm appropriate monitoring of patient

Drug	Start date	Route	Dose	Stop date	Additional info.	Sign/print/contact	Pharmacy

Times: 08, 12, 14, 18, 22, 24

Month / Year Patient Name: NHS No / Hospital No:

REGULAR PRESCRIPTIONS

Time \ Date

Drug	Start date	Route	Dose	Stop date	Additional info.	Sign/print/contact	Pharmacy

Times: 08, 12, 14, 18, 22, 24

Month / Year

Patient Name:

NHS No / Hospital No:

REGULAR PRESCRIPTIONS

			Time	Date														
Drug			08															
			12															
Start date	Route	Dose	14															
Stop date	Additional info.		18															
Sign/print/contact		Pharmacy	22															
			24															
Drug			08															
			12															
Start date	Route	Dose	14															
Stop date	Additional info.		18															
Sign/print/contact		Pharmacy	22															
			24															
Drug			08															
			12															
Start date	Route	Dose	14															
Stop date	Additional info.		18															
Sign/print/contact		Pharmacy	22															
			24															
Drug			08															
			12															
Start date	Route	Dose	14															
Stop date	Additional info.		18															
Sign/print/contact		Pharmacy	22															
			24															
Drug			08															
			12															
Start date	Route	Dose	14															
Stop date	Additional info.		18															
Sign/print/contact		Pharmacy	22															
			24															
Drug			08															
			12															
Start date	Route	Dose	14															
Stop date	Additional info.		18															
Sign/print/contact		Pharmacy	22															
			24															

Month / Year

Patient Name:

NHS No / Hospital No:

REGULAR PRESCRIPTIONS

			Time	Date														
Drug			08															
			12															
Start date	Route	Dose	14															
Stop date	Additional info.		18															
Sign/print/contact		Pharmacy	22															
			24															
Drug			08															
			12															
Start date	Route	Dose	14															
Stop date	Additional info.		18															
Sign/print/contact		Pharmacy	22															
			24															
Drug			08															
			12															
Start date	Route	Dose	14															
Stop date	Additional info.		18															
Sign/print/contact		Pharmacy	22															
			24															
Drug			08															
			12															
Start date	Route	Dose	14															
Stop date	Additional info.		18															
Sign/print/contact		Pharmacy	22															
			24															
Drug			08															
			12															
Start date	Route	Dose	14															
Stop date	Additional info.		18															
Sign/print/contact		Pharmacy	22															
			24															
Drug			08															
			12															
Start date	Route	Dose	14															
Stop date	Additional info.		18															
Sign/print/contact		Pharmacy	22															
			24															

Month / Year Patient Name: NHS No / Hospital No:

ANTIMICROBIAL SECTION

Drug Allergies / Adverse Drug Reactions - State if no known drug allergies		Completed by (sign)	Date:
Drug(s):	Reaction:		

This chart is for **all treatment dose antimicrobials except once daily gentamicin** which should be prescribed on the front of this chart in the once only section.

In keeping with good antimicrobial stewardship with all prescriptions you must: **State the indication** i.e. the actual or presumed source of infection.

Prescribe in line with approved Trust Guidelines or after consultation with a Consultant Microbiologist and/or in light of relevant cultures and sensitivities.
The rationale for the choice of agent should be documented in the medical notes and indicated on the prescription (including prophylactic regimens).

Antimicrobial therapy should be reviewed daily but formally around 48 hours and 5 days signing and dating the review boxes. Consider IV to oral switch and de-escalation as and when appropriate (re-writing any oral agent using a new prescription box). If the antimicrobials are to continue beyond 7 days you must record in the medical notes the rationale and then endorse the prescription in the box provided. Where no documentation or endorsement exists treatment will be stopped in line with the Antimicrobial Stop Policy.
If the review boxes are likely to correspond to weekend or bank holidays please revew in advance to ensure no unintentional interruption to treatment.

Note: The day of treatment (Day of Tx) box indicates the total duration of antimicrobial use since the initial prescription.

Drug	**Dose**	Route	Date →								To continue ≥ 7 days you MUST document indication here
			Day of Tx								
Start date	Indication	Per guidelines ☐	02:00								
		Micro approved ☐	06:00								
Signature / Print	Estimated stop date:		10:00								
Bleep/contact			12:00								
Reviewed at 48 hrs	Additional information		14:00								
Sign Date			18:00								
Reviewed at 5 days	Pharmacy		22:00								
Sign Date			24:00								
Drug	**Dose**	Route	Date →								To continue ≥ 7 days you MUST document indication here
			Day of Tx								
Start date	Indication	Per guidelines ☐	02:00								
		Micro approved ☐	06:00								
Signature / Print	Estimated stop date:		10:00								
Bleep/contact			12:00								
Reviewed at 48 hrs	Additional information		14:00								
Sign Date			18:00								
Reviewed at 5 days	Pharmacy		22:00								
Sign Date			24:00								
Drug	**Dose**	Route	Date →								To continue ≥ 7 days you MUST document indication here
			Day of Tx								
Start date	Indication	Per guidelines ☐	02:00								
		Micro approved ☐	06:00								
Signature / Print	Estimated stop date:		10:00								
Bleep/contact			12:00								
Reviewed at 48 hrs	Additional information		14:00								
Sign Date			18:00								
Reviewed at 5 days	Pharmacy		22:00								
Sign Date			24:00								
Drug	**Dose**	Route	Date →								To continue ≥ 7 days you MUST document indication here
			Day of Tx								
Start date	Indication	Per guidelines ☐	02:00								
		Micro approved ☐	06:00								
Signature / Print	Estimated stop date:		10:00								
Bleep/contact			12:00								
Reviewed at 48 hrs	Additional information		14:00								
Sign Date			18:00								
Reviewed at 5 days	Pharmacy		22:00								
Sign Date			24:00								
Drug	**Dose**	Route	Date →								To continue ≥ 7 days you MUST document indication here
			Day of Tx								
Start date	Indication	Per guidelines ☐	02:00								
		Micro approved ☐	06:00								
Signature / Print	Estimated stop date:		10:00								
Bleep/contact			12:00								
Reviewed at 48 hrs	Additional information		14:00								
Sign Date			18:00								
Reviewed at 5 days	Pharmacy		22:00								
Sign Date			24:00								

Month / Year Patient Name: NHS No / Hospital No:

AS REQUIRED PRESCRIPTIONS

Sodium chloride 0.9%	**5 – 20ml**	Date															
		Time															
IV flush	As needed	Dose															
Start date	Pre and post injection/infusions and to maintain line patency	Route															
Sign/print/contact	Pharmacy	Given by															
Drug	Dose	Date															
		Time															
Route	Max frequency	Dose															
Start date	Indication	Route															
Sign/print/contact	Pharmacy	Given by															
Drug	Dose	Date															
		Time															
Route	Max frequency	Dose															
Start date	Indication	Route															
Sign/print/contact	Pharmacy	Given by															
Drug	Dose	Date															
		Time															
Route	Max frequency	Dose															
Start date	Indication	Route															
Sign/print/contact	Pharmacy	Given by															
Drug	Dose	Date															
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Route	Max frequency	Dose															
Start date	Indication	Route															
Sign/print/contact	Pharmacy	Given by															
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Route	Max frequency	Dose															
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Sign/print/contact	Pharmacy	Given by															
Drug	Dose	Date															
		Time															
Route	Max frequency	Dose															
Start date	Indication	Route															
Sign/print/contact	Pharmacy	Given by															

Month / Year Patient Name: NHS No / Hospital No:

AS REQUIRED PRESCRIPTIONS

Drug		Dose	Date														
			Time														
Route	Max frequency		Dose														
Start date	Indication		Route														
Sign/print/contact		Pharmacy	Given by														
Drug		Dose	Date														
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Sign/print/contact		Pharmacy	Given by														
Drug		Dose	Date														
			Time														
Route	Max frequency		Dose														
Start date	Indication		Route														
Sign/print/contact		Pharmacy	Given by														

Month / Year Patient Name: NHS No / Hospital No:

AS REQUIRED PRESCRIPTIONS

Drug		Dose	Date														
			Time														
Route	Max frequency		Dose														
Start date	Indication		Route														
Sign/print/contact		Pharmacy	Given by														
Drug		Dose	Date														
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Route	Max frequency		Dose														
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Drug		Dose	Date														
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Route	Max frequency		Dose														
Start date	Indication		Route														
Sign/print/contact		Pharmacy	Given by														
Drug		Dose	Date														
			Time														
Route	Max frequency		Dose														
Start date	Indication		Route														
Sign/print/contact		Pharmacy	Given by														

Subcutaneous Insulin Chart

Patient name: _____ **Hospital No** _____

Prescribe initial dose in first column. If any dose changes are required DELETE THE WHOLE PREVIOUS COLUMN and rewrite doses for ALL insulin used in dose change columns

	Insulin: exact type/brand (no abbreviations)	Initial Dose	Dose change 1	Dose change 2	Dose change 3	Dose change 4	NURSES – Record dose administered and time below If the patient self administers this must be observed under supervision Always use an insulin syringe or a standard insulin device Date
Breakfast	Type	Units	Units	Units	Units	Units	Dose Units
	Sign/contact	Date	Sign Date	Sign Date	Sign Date	Sign Date	Time Sign
	Type	Units	Units	Units	Units	Units	Dose Units
	Sign/contact	Date	Sign Date	Sign Date	Sign Date	Sign Date	Time Sign
Lunch	Type	Units	Units	Units	Units	Units	Dose Units
	Sign/contact	Date	Sign Date	Sign Date	Sign Date	Sign Date	Time Sign
	Type	Units	Units	Units	Units	Units	Dose Units
	Sign/contact	Date	Sign Date	Sign Date	Sign Date	Sign Date	Time Sign
Evening meal	Type	Units	Units	Units	Units	Units	Dose Units
	Sign/contact	Date	Sign Date	Sign Date	Sign Date	Sign Date	Time Sign
	Type	Units	Units	Units	Units	Units	Dose Units
	Sign/contact	Date	Sign Date	Sign Date	Sign Date	Sign Date	Time Sign
Bed	Type	Units	Units	Units	Units	Units	Dose Units
	Sign/contact	Date	Sign Date	Sign Date	Sign Date	Sign Date	Time Sign
	Type	Units	Units	Units	Units	Units	Dose Units
	Sign/contact	Date	Sign Date	Sign Date	Sign Date	Sign Date	Time Sign
Pharmacy check/ comments			Supply details				

Blood Glucose Monitoring Chart

Month / Year

Patient Name:

NHS No / Hospital No:

Date																																			
	Breakfast		Lunch		Evening Meal		Bed	Breakfast		Lunch		Evening Meal		Bed	Breakfast		Lunch		Evening Meal		Bed	Breakfast		Lunch		Evening Meal		Bed	Breakfast		Lunch		Evening Meal		Bed	Breakfast		Lunch		Evening Meal		Bed
	Pre	Post	Pre	Post	Pre	Post		Pre	Post	Pre	Post	Pre	Post		Pre	Post	Pre	Post	Pre	Post		Pre	Post	Pre	Post	Pre	Post		Pre	Post	Pre	Post	Pre	Post		Pre	Post	Pre	Post	Pre	Post	
Time / Glucose																																										
>22 record value																																										
21																																										
20																																										
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5																																										
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<3.9 record value																																										

>19	Refer to medical/diabetes team
11.1 - 18.9	Review and consider referral to medical team
4-11	Continue Monitoring
≤3.9	Follow Trust Hypoglycaemia Guideline and refer to medical/diabetes team

Record high frequency glucose readings taken during the treatment of hypoglycaemia (every 15mins as per guideline)	Date			Date			Date		
	Time	Glucose	Treatment	Time	Glucose	Treatment	Time	Glucose	Treatment

Blood Glucose Monitoring Chart

Month / Year

Patient Name:

NHS No / Hospital No:

Date	Breakfast		Lunch		Evening Meal		Bed	Breakfast		Lunch		Evening Meal		Bed	Breakfast		Lunch		Evening Meal		Bed	Breakfast		Lunch		Evening Meal		Bed	Breakfast		Lunch		Evening Meal		Bed	Breakfast		Lunch		Evening Meal		Bed	Breakfast		Lunch		Evening Meal		Bed
	Pre	Post	Pre	Post	Pre	Post		Pre	Post	Pre	Post	Pre	Post		Pre	Post	Pre	Post	Pre	Post		Pre	Post	Pre	Post	Pre	Post		Pre	Post	Pre	Post	Pre	Post		Pre	Post	Pre	Post	Pre	Post		Pre	Post	Pre	Post	Pre	Post	
Time / Glucose																																																	
>22 record value																																																	
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4																																																	
<3.9 record value																																																	

>19	Refer to medical/diabetes team
11.1 - 18.9	Review and consider referral to medical team
4-11	Continue Monitoring
≤3.9	Follow Trust Hypoglycaemia Guideline and refer to medical/diabetes team

Record high frequency glucose readings taken during the treatment of hypoglycaemia (every 15mins as per guideline)	Date			Date			Date		
	Time	Glucose	Treatment	Time	Glucose	Treatment	Time	Glucose	Treatment

Variable Rate Intravenous Insulin Infusion (VRIII)

Prescription Chart

Patient name: ______________________ **Hospital No** _________

1. Prescribe Insulin for Infusion

Nurses : Always use an insulin syringe to draw up insulin

Date	Intravenous fluid	Volume	Additive drug	Prescribers signature	Prescriber Bleep/contact	Time started	Time stopped	Serial/Batch No of insulin	Nursing signature	Nursing signature
	Sodium Chloride 0.9%	49.5 ml	Human Actrapid 50 units							
	Sodium Chloride 0.9%	49.5 ml	Human Actrapid 50 units							
	Sodium Chloride 0.9%	49.5 ml	Human Actrapid 50 units							
	Sodium Chloride 0.9%	49.5 ml	Human Actrapid 50 units							

2. Prescribe insulin rates to be used

DOCTORS: If you wish to change the scale used, cross out the scale no longer required, and sign the new scale. **NURSES:** Check blood glucose every hour.	Scale 1 Standard		Scale 2 If not achieving target or BMI 35 kg /m^2		Scale 3 Customised	
	Glucose	Insulin Rate Units/hour	Glucose	Insulin Rate Units/hour	Glucose	Insulin Rate Units/hour
	<4	0.5 Follow hypo guideline	<4	0.5 Follow hypo guideline		
	4.1-7.0	1	4.1-7.0	2		
	7.1-9.0	2	7.1-9.0	3		
	9.1-11.0	3	9.1-11.0	4		
	11.1-14.0	4	11.1-14.0	5		
	14.1-17.0	5	14.1-17.0	6		
	17.1-19	6	17.1-19	7		
	>19	Seek Diabetes/ medical attention	>19	Seek Diabetes/ medical attention		
Date/Time						
Signature						

Guidance

Scale 1. Use this scale initially. Review after 4 hours and change to scale 2 if targets not achieved. If need to go back again to scale 1 – rewrite using customised scale columns. Use a new chart if there are no spaces left.

Scale 2. Start on this scale in patients with Type 2 diabetes with a BMI >35kg/m^2.

Scale 3. Customised scale for use if previous scales not achieving targets. Seek advice from the diabetes team.

For DKA use the ICP provided with the Adult DKA Guidance.
NB. 16yr and 17yr old patients must use Paediatric DKA Guidance

HHS and ACS - See trust Guideline for the management of these conditions and prescribe in Customised Scale 3.

Remember

1. **If the patient usually takes basal insulin (e.g levemir/ glargine) this must be continued even whilst on VRIII**
2. When discontinuing VRIII, give the next subcutaneous insulin dose due then stop IV insulin **30 minutes LATER**
3. Prescribe accompanying fluids
4. Intercurrent illness often increases insulin requirements

Month / Year | Patient Name: | NHS No / Hospital No:

Variable Rate Intravenous Insulin Infusion (VRIII) and High Frequency Monitoring Chart.

Please refer to diabetes team at 48hrs or earlier if problems with control.

Day 1 Date:	Day 2 Date:	Day 3 Date:	Day 4 Date:
Pump asset no:	Doctor Review (Sign)	Doctor Review (Sign)	Doctor Review (Sign)
	Date / Time	Date / Time	Date / Time

Time	Glucose mmol/litre	Rate (units per hr)	Blood ketones	Nurse sign	Time	Glucose mmol/litre	Rate (units per hr)	Blood ketones	Nurse sign	Time	Glucose mmol/litre	Rate (units per hr)	Blood ketones	Nurse sign	Time	Glucose mmol/litre	Rate (units per hr)	Blood ketones	Nurse sign

Month / Year | Patient Name: | NHS No / Hospital No:

Please refer to diabetes team at 48hrs or earlier if problems with control.

Day 5 Date:	Day 6 Date:
Doctor Review (Sign)	Doctor Review (Sign)
Date / Time	Date / Time

Time	Glucose mmol/litre	Rate (units per hr)	Blood ketones	Nurse sign	Time	Glucose mmol/litre	Rate (units per hr)	Blood ketones	Nurse sign

For use by diabetes team only

CS11 Settings

Pump Type **Insulin Type**

Signature **Date**

Time	Basal rate Units per hour						Bolus ☐ units per ☐ g CHO			
	Initial rate	Sign/ date	Review 1	Sign/ date	Review 2	Sign/ date	Initial	Sign/ date	Review	Sign/ date
00:00-01:00										
01:00-02:00										
02:00-03:00										
03:00-04:00										
04:00-05:00										
05:00-06:00										
06:00-07:00										
07:00-08:00										
08:00-09:00										
09:00-10:00										
10:00-11:00										
11:00-12:00										
12:00-13:00										
13:00-14:00										
14:00-15:00										
15:00-16:00										
16:00-17:00										
17:00-18:00										
18:00-19:00										
19:00-20:00										
20:00-21:00										
21:00-22:00										
22:00-23:00										
23:00-24:00										

Month / Year Patient Name: NHS No / Hospital No:

PARENTERAL INFUSION PRESCRIPTION AND RECORD OF ADMINISTRATION

Use of chart prescribers:
1) Ensure the patient has patent access before prescribing
2) Prescribe only those drugs to be given by infusion
3) State clearly the line through which infusion is to be administered e.g. intravenous, central venous pressure (CVP) line, subcutaneous
4) Ensure urea and electrolytes are monitored appropriately

Use of chart nurses:
1) Clearly endorse time started and time stopped
2) Ensure fluid balance chart is completed appropriately
3) Ensure VIP scores are recorded and acted upon accordingly

Date	Intravenous fluid	Volume	Rate/duration	Route/line	Additive/Drug		Prescribers signature	Bleep/ contact details	Pharmacy notes	Drug added by/time		Administration						
					Approved name	Dose				Signature	time	Serial/Batch No. of drug added or blood/biological products	Blood		Time started	Time stopped	Sig	
													Group	Rh				

Month / Year Patient Name: NHS No / Hospital No:

Date	Intravenous fluid	Volume	Rate/duration	Route/line	Additive/Drug		Prescribers signature	Bleep/ contact details	Pharmacy notes	Drug added by/time		Administration						
					Approved name	Dose				Signature	time	Serial/Batch No. of drug added or blood/biological products	Blood		Time started	Time stopped	Sig	
													Group	Rh				

Month / Year

Patient Name:

NHS No / Hospital No:

Date	Intravenous fluid	Volume	Rate/duration	Route/line	Additive/Drug		Prescribers signature	Bleep/ contact details	Pharmacy notes	Drug added by/time		Administration						
					Approved name	Dose				Signature	time	Serial/Batch No. of drug added or blood/biological products	Blood		Time started	Time stopped	Sig	
													Group	Rh				