The Fall 2018 ADE Hypoglycemia Relay consisted of 3 focused virtual events designed to assist hospitals in assessing the root causes of ADE hypoglycemia harms and provide guidance and support on how to address ADE Hypoglycemia challenges and gaps in practices.

The tools and resources that were utilized in the Relay were: the Mini RCA ADE Hypoglycemia Process Discovery Tool, the ADE Hypoglycemia Coaching Guide, and the HRET HIIN ADE Change Package. High performers in the 2018 Summer ADE Hypoglycemia Sprint acted as peer advisors for participants.

**KEY CLINICAL INTERVENTIONS**

- Target 140-180mg/dl glucose range, not normoglycemia
- Use basal + bolus + correction insulin on all non-NPO patients prescribed insulin in hospitals and basal + correction insulin on all NPO patients prescribed insulin in hospitals
- Eliminate sliding scale insulin as the sole means of glycemic control
- Adjust the insulin regimen after a single episode of hypoglycemia (glucose <70 mg/dl)
- Regularly monitoring of signs and symptoms for patients on insulin
- Educate and engage patients and their families on ADE hypoglycemia risks and self-management

**DISCOVERY TOOL INFORMATION**

10 hospitals who participated in the Relay utilized the Mini RCA ADE Process Improvement Discovery Tool to identify gaps in ADE hypoglycemia prevention practices and submitted their results for review. Common discoveries were:

- Not modifying the regimen when glucose is <100 mg/dL or < 70 mg/dL
- Not providing patients with basal insulin.
- Patients managed with sliding scale insulin alone.

**RESULTS OF THE RELAY**

The ADE Hypoglycemia Relay process measures are based on 10 participants who took both the pre and post assessments:

- **As a result of the relay, more hospitals are starting to plan:**
  - Setting target glucose levels at 140-180 mg/dl in the hospitalized patient.
  - Eliminating “sliding scale” insulin as the sole method of glycemic management (Managing all patients with basal + bolus + correction if eating, and basal + bolus if not eating)

Does your hospital eliminate “sliding scale” insulin as the sole method of glycemic management? (Manage all patients with basal + bolus + correction if eating, and basal + bolus if not eating)

<table>
<thead>
<tr>
<th></th>
<th>Pre-Assessment</th>
<th>Post-Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not thinking about it</td>
<td>71.4%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Just starting to plan</td>
<td>28.6%</td>
<td>71.4%</td>
</tr>
<tr>
<td>Spread to multiple units</td>
<td>0.0%</td>
<td>14.3%</td>
</tr>
</tbody>
</table>
RESULTS OF THE RELAY CONTINUED

» Changing insulin orders for every patient following a single episode of inpatient hypoglycemia (< 70 mg/dL).
» Encouraging patient/family participation in bedside report and/or shift change huddles to facilitate discussions regarding treatment and prevention of ADE hypoglycemia.

> As a result of the relay, more hospitals have implemented the following across multiple units:
» Eliminating “sliding scale” insulin as the sole method of glycemic management (Managing all patients with basal + bolus + correction if eating, and basal + bolus if not eating)
» Changing insulin orders for every patient following a single episode of inpatient hypoglycemia (< 70 mg/dL)

LESSONS LEARNED

> Peer hospital guidance and support provided insight on how frontline staff can practically utilize ADE Hypoglycemia tools and resources as well as providing continuing support outside of the virtual events.
> Focusing on severe hypoglycemic patients (<50 mg/dl BGL) when utilizing the ADE Hypoglycemia Process Improvement Discovery Tool provided the most helpful information.
> Patient and family engagement in preventing ADE hypoglycemia can be integrated through sharing of the pre-admission checklist with patients and their families and involving them in shift change huddles or bedside reporting.
> The Process Improvement Discovery Tool and coaching guide provided a great visual and incredible insight into ADE hypoglycemia practices. Additionally, both tools assisted in engaging leadership buy-in in changing ADE hypoglycemia practices in hospitals.
> Culture changes are required to shift from solely using “sliding scale” insulin for glycemic management to basal + bolus + correction if the patient is eating and basal + bolus if the patient is not eating.

The Coaching Guide is excellent — a great way to assure a thorough process improvement approach.

The ADE Hypoglycemia Process Improvement Discovery Tool provided a great visual snapshot of our process issues that we were easily able to share with our leadership.

It was nice to be able to reach out to peer advisors for guidance on how to use the RCA tool and figure out how to overcome ADE hypoglycemia challenges in our hospital.

For more information, contact HIIN@aha.org or visit our website and, under Topics, click on ADE to learn about the ADE Hypoglycemia Relay and view recordings: www.hret-hiin.org