### Revision History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date of Revision</th>
<th>Description of Revision</th>
<th>Revised By</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td></td>
<td>Completion of Topic</td>
<td>Dr. Shannon Ruzycki, Leta Philp</td>
</tr>
</tbody>
</table>
Important Information Before You Begin

The recommendations contained in this knowledge topic have been provincially adjudicated and are based on best practice and available evidence. Clinicians applying these recommendations should, in consultation with the patient, use independent medical judgment in the context of individual clinical circumstances to direct care. This knowledge topic will be reviewed periodically and updated as best practice evidence and practice change.

The information in this topic strives to adhere to Institute for Safe Medication Practices (ISMP) safety standards and align with Quality and Safety initiatives and accreditation requirements such as the Required Organizational Practices. Some examples of these initiatives or groups are: Health Quality Council Alberta (HQCA), Choosing Wisely, Safer Healthcare Now, and Accreditation Canada etc.

Guidelines

This Clinical Knowledge Topic is based on the following guidelines and/or resources:

- The Diabetes Canada Clinical Practice Guidelines
- Peri-operative Management of the Surgical Patients with Diabetes 2015
- Perioperative Hyperglycemia Management: An Update 2017
- Enhanced Recovery After Surgery: Subject Guide
- Basal Bolus Insulin Therapy Website
  - How to BBIT: An Educational Resource for Prescribers AHS Adult Subcutaneous Basal Bolus Insulin Therapy (BBIT)

Keywords

- Diabetes
- Insulin
- Pre op Diabetes
- Post op Diabetes
- Diabetes mellitus
- Perioperative
- Preoperative
- Intraoperative
- Postoperative
Decision Making

Goals
Patients with diabetes represent between 10 to 40% of patients undergoing surgery. Patients with diabetes are known to have a greater number of complications, higher mortality, and longer length of stays postoperatively compared with patients without diabetes. Poor outcomes are more common in patients with diabetes who have worse glycemic control in the preoperative, intraoperative, and postoperative period. Fortunately, perioperative euglycemia has been demonstrated to improve these outcomes.

Patients with diabetes represent a heterogeneous population including well-controlled patients or poorly-controlled patients with type 1 diabetes, well-controlled patients or poorly-controlled patients with type 2 diabetes, monogenic diabetes and other non-type 1, non-type 2 diabetes who may or may not require insulin, and patients with unrecognized diabetes. Each group requires individualized preoperative, intraoperative, and postoperative management to maintain euglycemia and reduce perioperative morbidity and mortality.

The Perioperative Management of Patients with Diabetes Order Sets are intended to provide best-practice recommendations for management of patients with diabetes in the perioperative period. The order sets address two populations, patients with type 1 diabetes and patients with type 2 diabetes in the pre-admission clinic and the immediate preoperative area and postoperatively. Principals from this order set can be applied to patients with non-type 1, non-type 2 diabetes who require insulin (such as post-pancreatectomy patients). This order set is not intended to be used for pregnant women with diabetes. Dose guidance provided within the order set may not be relevant and will require clinical judgment.
Pre-Admission Clinic Management of Patients with Diabetes

Requiring Insulin Order Set – This order set provides instructions for insulin management for patients undergoing surgery. It can be used for emergent/urgent surgery. It can be used in conjunction (not to replace ERAS) with any surgery order set (ERAS or non-ERAS)

Order Set Restrictions: Not for pregnant women with diabetes, patients younger than 18 years of age
Order Set Keywords: Perioperative diabetes management

Before Day of Procedure

Patients with diabetes who require insulin should be booked as the first case of the day when possible

✔ Clinical communication: Please book surgery as first case of the day for patients with diabetes.

Diet and Nutrition

Carbohydrate loading is not recommended for patients with diabetes undergoing scheduled surgical intervention requiring anesthesia care. Current available evidence has shown no clear benefit with routine use of carbohydrate loading among patients with diabetes. There is potential harm arising from hyperglycemia in the peri-operative period for this population. The Clinical Knowledge Topic working group recommends against carbohydrate loading in patients with diabetes until prospective trials have been completed in this population.

✔ Teach: AHS Eating and Drinking Before Surgery: Patient Instructions.

Laboratory Investigations Routine

Chemistry

For patients with a Hemoglobin A1C greater than 8.5%, consider a referral to the appropriate services as per hospital/site availability (i.e. Endocrinology, General Internal Medicine, diabetes education program/health care team or Family Physician with diabetes expertise). Hemoglobin A1C should be done within 3 months prior to surgery.

Order if not already completed in the last 3 months

☐ Hemoglobin A1C
Medications

**Diabetic Agents**

*Perioperative insulin management in patients with type 1 diabetes. Add orders for insulin dose and type of insulin below. Adapted from Barker et al. 2015.*

For patients self-managing with insulin pump therapy at home, refer to [AHS Guidelines for Safe Management of Insulin Pump Therapy in Hospital](#) and consult the patient’s diabetes care team or endocrinologist or internist.

<table>
<thead>
<tr>
<th>Insulin Type</th>
<th>Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basal Insulin</strong></td>
<td>Administer usual dose of insulin prior to surgery. If patient has higher risk of hypoglycemia as defined by consult with GIM or Endocrinology consider reducing dose to 80-90% of usual dose in 24 hours prior to surgery</td>
</tr>
<tr>
<td>Long-acting and</td>
<td>Evening Before Surgery: Administer the usual dose of insulin on the night before surgery</td>
</tr>
<tr>
<td>Ultra-long insulin</td>
<td>Morning of Surgery: Administer 50% of the usual insulin dose morning dose on the day of surgery</td>
</tr>
<tr>
<td>Intermediate-acting insulin</td>
<td><em>Note: evening dose is administered on the day before surgery.</em></td>
</tr>
<tr>
<td><strong>Bolus Insulin</strong></td>
<td>Administer usual dose if patient is eating and drinking well</td>
</tr>
<tr>
<td>Short-acting and</td>
<td>Evening Before Surgery: Administer the usual dose of insulin on the night before surgery</td>
</tr>
<tr>
<td>Rapid-acting insulin</td>
<td>Morning of Surgery: Hold while NPO</td>
</tr>
<tr>
<td><strong>Correction Insulin</strong></td>
<td>Administer usual dose if blood glucose is out of target even while NPO</td>
</tr>
<tr>
<td>Short-acting and</td>
<td></td>
</tr>
<tr>
<td>Rapid-acting insulin</td>
<td></td>
</tr>
</tbody>
</table>

☐ Teach: Authorized Prescriber to complete insulin dosage below. Provide patient instructions for Preoperative Diabetes Medications as per below:

- Basal insulin SHOULD NOT be held if you have type 1 diabetes EVEN when you are not eating/drinking for surgery.
- Basal insulin
  - insulin ____________ (glargine {Lantus®} OR detemir {Levemir®} OR other: specify) ____________ units SUBCUTANEOUSLY ONCE ____________ on the (AM on the day before surgery OR PM on the day before surgery OR AM on the day of surgery)
- Intermediate-acting insulin
  - insulin ____________ (NPH {HumuLIN® N} OR other: specify) ____________ units SUBCUTANEOUSLY ONCE ____________ on the (PM on the day before surgery OR AM on day of surgery)
  - insulin ____________ (other: specify) _____ units SUBCUTANEOUSLY ONCE in the PM on the day before surgery
• Bolus and Correction insulin
  o Take as per your home regimen. Do NOT take bolus insulin when you are not eating/drinking for surgery. You may take correction insulin if your blood sugar is out of target.

Consults/Referrals
Inpatient Specialty Consults
For patients with a Hemoglobin A1C greater than 8.5%, wide fluctuation in glucose and frequent hypoglycemic, consider a referral to the appropriate services as per hospital/site availability (i.e. Endocrinology, General Internal Medicine, diabetes education program/health care team or Family Physician with diabetes expertise). For patients on insulin pump therapy, consult the patient’s diabetes care team, endocrinologist or internist and refer to Insulin Pump In-Hospital Therapy – ipumpit.ca

☐ Consult Internal Medicine
☐ Consult Endocrinology
☐ Consult Hospitalist
☐ Consult Family Physician with diabetes expertise
Consult (other): __________________

Referrals
☐ Referral to Diabetes Education Program/Health Care Team (resources as applicable)
Day of Surgery Management for Patients with Diabetes on Insulin

**Order Set** - This order set provides instructions for general management for patients undergoing surgery and is intended to be completed in the pre-admission clinic for use in the immediate preoperative area on the day of surgery. It can be used for emergent/urgent surgery.

**Order Set Restrictions:** Pregnant women with diabetes, patients younger than 18 years of age
**Order Set Keywords:** Perioperative diabetes management
**Order Set Requirements:** Weight

### Day of Procedure

#### Diet and Nutrition

The minimum duration of pre-operative fasting prior to the administration of anesthesia should be 8 hours after a meal that includes meat or fried or fatty foods, 6 hours after a light meal (such as toast and a clear fluid), 2 hours after clear fluids.

Pre-operative eating and drinking
- Clinical Communication: Final snack 8 hours prior to scheduled surgery
- Clinical Communication: Clear Fluids until 3 hours prior to scheduled surgery
- NPO 2 hours prior to scheduled surgery

#### Patient Care

**Point Of Care Testing Glucose**
- **Blood Glucose Monitoring POCT:** AM of surgery

  *For Type 1: suggest every 2 hours in fasting patients who require insulin and every 4 hours in patients with diabetes who do not require insulin.*

- **Blood Glucose Monitoring POCT:** every ______ hour(s)
- Clinical Communication – If blood glucose less than 4.0 mmol/L initiate Hypoglycemia Procedure
- Clinical Communication – If blood glucose is greater than 18.0 mmol/L OR if patient on insulin pump and blood glucose is greater than 14.0 mmol/L, initiate Hyperglycemia Procedure, notify Authorized Prescriber and collect ketones

#### Laboratory Investigations Routine

*For Ketone Testing for Suspected Diabetic Ketoacidosis.*
- Nursing Communication: If patient has symptoms of Diabetic Ketoacidosis order Beta-Hydroxybutyrate if available. Symptoms include but not limited to polyuria, thirst, nausea/vomiting, abdominal pain, weakness, mental status change, recent weight loss, and coma)
  - Conditional Order: Available for nurse to activate if
    1. Patient has a blood glucose of greater than 18.0 mmol/L
    2. Patient has a blood glucose of greater than 14.0 mmol/L on self-management of insulin pump therapy

**Chemistry**

*Serum Ketones preferred over Urine Ketones for diagnosis of DKA*
- Beta-Hydroxybutyrate
Urine

*If patient has symptoms of Diabetic Ketoacidosis order Beta-Hydroxybutyrate if available*

- Urine Ketones
- POCT Urine Ketones Dipstick Urinalysis if available

**Medications**

Diabetic Agents

*Calculated Total Daily Dose (TDD) for this order: ____________________*

When NPO, if Blood Glucose is Greater than 10.0 mmol/L – Use Correction Insulin for Hyperglycemia:

*For patients with known home regimen – use custom option to order patient’s usual correction insulin brand and dosing. For patients with unknown home insulin regimen, calculate the patient’s total daily dose (TDD) of home insulin using 0.3 units/kg/day and choose correction dose below. Patients who are not eating and drinking must still receive basal and correction insulin*

Choose ONE

*Use the same insulin (rapid or short-acting) for bolus (when eating) and correction*

- insulin lispro (Humalog®) SUBCUTANEOUSLY PRN for Blood Glucose greater than 10.0 mmol/L
- insulin aspart (Novorapid®) SUBCUTANEOUSLY PRN for Blood Glucose greater than 10.0 mmol/L
- insulin regular (Humulin® R) SUBCUTANEOUSLY PRN for Blood Glucose greater than 10.0 mmol/L

☑ Clinical Communication - Correction dose to be determined and administered with/before meal/enteral feed OR at scheduled mealtime if NPO. Bedtime correction not routinely recommended. Correction and bolus doses can be combined and administered as a single subcutaneous injection.

☑ Nursing Communication: Patients who are not eating and drinking must still receive basal and correction insulin

Choose ONE correction insulin (below) based on current Total Daily Dose (TDD)

*Use the same insulin (rapid or short-acting) for bolus (when eating) and correction*

**If TDD is 15-30 units**

- insulin correction SUBCUTANEOUSLY TID with mealtime based on Blood Glucose reading
  - 0 unit if Blood Glucose 4.1 – 10.0 mmol/L
  - 1 unit if Blood Glucose 10.1 – 14.0 mmol/L
  - 2 units if Blood Glucose 14.1 – 18.0 mmol/L
If TDD is **31-50 units**

- insulin correction SUBCUTANEOUSLY TID with mealtime based on Blood Glucose reading
  - 0 unit if Blood Glucose 4.1 – 10.0 mmol/L
  - 1 unit if Blood Glucose 10.1 – 12.0 mmol/L
  - 2 units if Blood Glucose 12.1 – 15.0 mmol/L
  - 3 units if Blood Glucose 15.1 – 18.0 mmol/L

If TDD is **51-80 units**

- insulin correction SUBCUTANEOUSLY TID with mealtime based on Blood Glucose reading
  - 0 unit if Blood Glucose 4.1 – 10.0 mmol/L
  - 2 units if Blood Glucose 10.1 – 12.0 mmol/L
  - 3 units if Blood Glucose 12.1 – 14.0 mmol/L
  - 4 units if Blood Glucose 14.1 – 16.0 mmol/L
  - 5 units if Blood Glucose 16.1 – 18.0 mmol/L

If TDD is **81 units or more**

- insulin correction SUBCUTANEOUSLY TID with mealtime based on Blood Glucose reading
  - 0 unit if Blood Glucose 4.1 – 10.0 mmol/L
  - 2 units if Blood Glucose 10.1 – 11.0 mmol/L
  - 4 units if Blood Glucose 11.1 – 13.0 mmol/L
  - 6 units if Blood Glucose 13.1 – 15.0 mmol/L
  - 8 units if Blood Glucose 15.1 – 17.0 mmol/L
  - 10 units if Blood Glucose 17.1 – 18.0 mmol/L

**Custom (Known Home Regimen, Post-pancreatectomy, Extreme Insulin Sensitivity or Resistance)**

- insulin correction SUBCUTANEOUSLY TID with mealtime based on Blood Glucose reading
  - ______ units if Blood Glucose ______ – ______ mmol/L
  - ______ units if Blood Glucose ______ – ______ mmol/L
  - ______ units if Blood Glucose ______ – ______ mmol/L
  - ______ units if Blood Glucose ______ – ______ mmol/L
  - ______ units if Blood Glucose ______ – ______ mmol/L
Intravenous Insulin

Subcutaneous insulin is preferred to intravenous insulin when possible. Consider intravenous insulin in patients with diabetes who will miss more than one meal, who have missed their basal insulin dose, patients with a Hemoglobin A1C greater than 8.5% or with patients who present with significant hyperglycemia (based on clinician’s judgement).

If blood glucose is greater than 10.0 mmol/L consideration should be given to continuous or intermittent bolus of IV insulin with blood glucose monitoring every 30-60min, while the patient is in the OR with the goal of keeping the blood glucose between 7.0 – 10.0 mmol/L (Bhamidipate et al 2011).

Continuous or intermittent IV bolus are superior to SC injections for long cases due to large variations in skin perfusion and therefore absorption during the preoperative period (Kadio et al 2012 and Alexanain et al 2011).

Recommend to transition to SC insulin before leaving the OR or to consult Endocrinology or Internal Medicine to transition if patient transferred to surgical unit on IV insulin, especially in patients with type 1 diabetes mellitus

Standard Concentration for Intravenous Insulin - 100 units per 100 mL (IV fluid provides 1 unit/mL). Mix as per AHS provincial Parenteral Monograph

IV insulin titration protocol

- Insulin regular (HumuLIN® R) IV infusion in Normal Saline in units/hour. Adjust insulin infusion every 1hour according to blood glucose results – see table below

<table>
<thead>
<tr>
<th>Blood Glucose (mmol/L)</th>
<th>Insulin Dose (units/hour)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 4.0</td>
<td>0 unit and activate Hypoglycemia Protocol</td>
</tr>
<tr>
<td>4.0 - 6.5</td>
<td>0.5 units/hour</td>
</tr>
<tr>
<td>6.6 - 9.0</td>
<td>1 unit/hour</td>
</tr>
<tr>
<td>9.1 - 12.0</td>
<td>2 units/hour</td>
</tr>
<tr>
<td>12.1 - 15.0</td>
<td>3 units/hour</td>
</tr>
<tr>
<td>15.1 - 18.0</td>
<td>4 units/hour</td>
</tr>
<tr>
<td>18.1 - 21.0</td>
<td>5 units/hour</td>
</tr>
<tr>
<td>21.1 - 24.0</td>
<td>6 units/hour</td>
</tr>
<tr>
<td>Greater than 24</td>
<td>8 units/hour</td>
</tr>
</tbody>
</table>
Postoperative Management for Patients with Diabetes on Insulin Order Set

Order Set Restrictions: Not for use in pregnant women with diabetes, patients younger than 18 years of age.
Order Set Keywords: Perioperative diabetes management

Post procedure Care

Diet and Nutrition
- ✔ Post-Surgical Transition Diet: start on POD 0
- ✔ Regular Diabetic – Adult Diet: start on POD 1
- □ Other diet ______

Patient Care
Point Of Care Testing Glucose
- ✔ Blood Glucose Monitoring POCT on arrival to unit (Post Anesthesia Care Unit and ward)
- ✔ Blood Glucose Monitoring POCT 4 times per day (15 - 30 minutes before scheduled meals and at bedtime) and PRN for suspected hypoglycemia
- □ Blood Glucose Monitoring POCT every ______ hour(s)
- □ Clinical Communication – If blood glucose less than 4.0 mmol/L initiate Hypoglycemia Procedure
- □ Clinical Communication – If blood glucose is greater than 18.0 mmol/L OR if patient on insulin pump and blood glucose is greater than 14.0 mmol/L, initiate Hyperglycemia Procedure, notify Authorized Prescriber and collect ketones

Laboratory Investigations Routine
For Ketone Testing for Suspected Diabetic Ketoacidosis.
- □ Nursing Communication: If patient has symptoms of Diabetic Ketoacidosis order Beta-Hydroxybutyrate if available. Symptoms include but not limited to polyuria, thirst, nausea/vomiting, abdominal pain, weakness, mental status change, recent weight loss, and coma)
  - ○ Conditional Order: Available for nurse to activate if
    1. Patient has a blood glucose of greater than 18.0 mmol/L
    2. Patient has a blood glucose of greater than 14.0 mmol/L on self-management of insulin pump therapy

Chemistry
- Serum Ketones preferred over Urine Ketones for diagnosis of DKA
- □ Beta-Hydroxybutyrate

Urine
- If patient has symptoms of Diabetic Ketoacidosis order Beta-Hydroxybutyrate if available
- □ Urine Ketones
- □ POCT Urine Ketones Dipstick Urinalysis if available
Medications

Diabetic Agents

Patients with type 1 diabetes require ongoing insulin in hospital. Patients with well-controlled diabetes should be transitioned to their home regimen when they are eating and drinking. **Patients who are not eating and drinking must still receive basal and correction insulin.** Patients who are eating and drinking will also require bolus insulin.

For IV insulin infusion - If required in ICU, critical units or specialty units with appropriate competency

- Nursing Communication: Patients who are not eating and drinking must still receive basal and correction insulin
- Continue IV insulin until the first scheduled subcutaneous basal insulin dose
- Discontinue the IV insulin 2 hours after the administration of basal (intermediate or long-acting) insulin (IV insulin has duration of action of about 7 minutes)
- Basal Bolus Insulin Therapy Order Set
- In-Hospital Orders for Self-Management of Insulin Pump
- Other medication(s): ________________________________

Consults/Referrals

Inpatient Specialty Consults

For management of diabetes in hospital, consider a referral to the appropriate services as per hospital/site availability (i.e. Endocrinology, General Internal Medicine, diabetes education program/health care team etc)

- Consult Internal Medicine
- Consult Endocrinology
- Consult Hospitalist
- Consult (other): ________________

Referrals

- Consult/Referral to Diabetes Education Program/Health Care Team (resources as applicable)

Discharge

Discharge Referrals

- Ensure diabetes follow up in the community
Pre-Admission Clinic Management of Patients with Diabetes NOT on Insulin Order Set - This order set provides instructions for management for patients with type 2 diabetes undergoing surgery and is intended for use in the pre-admission clinic. It can be used in conjunction (not to replace ERAS) with any surgery order set (ERAS or non-ERAS)

Order Set Restrictions: Not for use in patients with type 1 diabetes mellitus, pregnant women with diabetes, patients younger than 18 years of age
Order Set Keywords: Perioperative diabetes management

Before Day of Procedure
Patients with diabetes who require insulin should be booked as the first case of the day when possible

- Clinical communication: Please book surgery as first case of the day for patients with diabetes.

Diet and Nutrition
Carbohydrate loading is **not recommended** for patients with diabetes undergoing scheduled surgical intervention requiring anesthesia care. Current available evidence has shown no clear benefit with routine use of carbohydrate loading among patients with diabetes. There is potential harm arising from hyperglycemia in the peri-operative period for this population. The Clinical Knowledge Topic working group recommends against carbohydrate loading in patients with diabetes until prospective trials have been completed in this population.

- Teach: [AHS Eating and Drinking Before Surgery: Patient Instructions](#)

Laboratory Investigations Routine
Chemistry
For patients with a Hemoglobin A1C greater than 8.5%, consider a referral to the appropriate services as per hospital/site availability (i.e Endocrinology, General Internal Medicine, diabetes education program/health care team or Family Physician with diabetes expertise). Hemoglobin A1C should be done within 3 months prior to surgery.

- Order if not already completed in the last 3 months
  - Hemoglobin A1C
Medications
Diabetic Agents

Table 2 Perioperative medication recommendations for patients with type 2 diabetes who are on oral/non-insulin injectable antihyperglycemic agents

<table>
<thead>
<tr>
<th>Medication Class</th>
<th>Perioperative Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPP-IV inhibitors</td>
<td>Continue in the perioperative period</td>
</tr>
<tr>
<td>GLP-1 agonist</td>
<td>Continue in the perioperative period. This class is non-formulary on the AHS Provincial Drug Formulary (inpatient use if continued post operatively). Instruct patient to bring own supply.</td>
</tr>
<tr>
<td>Biguanides (Metformin)</td>
<td>Can safely be continued in the perioperative period. Consider holding the morning of surgery for patients at significant risk of acute kidney injury</td>
</tr>
<tr>
<td>Acarbose</td>
<td>Hold morning of surgery</td>
</tr>
<tr>
<td>Meglitinides (Repaglinide)</td>
<td>Hold morning of surgery</td>
</tr>
<tr>
<td>SGLT-2 inhibitors</td>
<td>Hold morning of surgery</td>
</tr>
<tr>
<td>Sulfonylureas</td>
<td>Hold morning of surgery</td>
</tr>
</tbody>
</table>

*Please note this not a comprehensive list of drugs, examples only.

☐ Teach: Authorized Prescriber to complete medication dosage below. Nurse to provide Patient Instructions for Preoperative Diabetes Medications as per below

- Continue the following medications on the day before and day of surgery:

- Do not take the following medications on the day of surgery:

- Administer one-half of your usual insulin dose of _________________ on the morning of surgery

Table 1 Perioperative insulin recommendations for patients with diabetes who require basal and bolus insulin

<table>
<thead>
<tr>
<th>Insulin Type</th>
<th>Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basal Insulin</td>
<td>Long-acting and Ultra-long action insulin: Administer usual dose of insulin prior to surgery. If patient has higher risk of hypoglycemia as defined by consult with GIM or Endocrinology consider reducing dose to 80-90% of usual dose in 24 hours prior to surgery</td>
</tr>
<tr>
<td>Intermediate-acting insulin</td>
<td><strong>Evening Before Surgery:</strong> Administer the usual dose of insulin on the night before surgery <strong>Morning of Surgery:</strong> Administer 50% of the usual insulin dose morning dose on the day of surgery</td>
</tr>
<tr>
<td>Bolus Insulin</td>
<td>Short-acting and Rapid-acting insulin: <strong>Evening Before Surgery:</strong> Administer usual dose if patient is eating and drinking well <strong>Morning of Surgery:</strong> Hold while NPO</td>
</tr>
<tr>
<td>Correction Insulin</td>
<td>Short-acting and Rapid-acting insulin: Administer usual dose if blood glucose is out of target even while NPO</td>
</tr>
</tbody>
</table>
Teach: Authorized Prescriber to complete insulin dosage below. Provide patient instructions for Preoperative Diabetes Medications as per below:

- Basal insulin
  - insulin ____________ (glargine (Lantus®) OR detemir (Levemir®) OR other: specify) ____________ units SUBCUTANEOUSLY ONCE ____________ on the (AM on the day before surgery OR PM on the day before surgery OR AM on the day of surgery)

- Intermediate-acting insulin
  - insulin ____________ (NPH (HumuLIN® N) OR other: specify) ____________ units SUBCUTANEOUSLY ONCE ____________ on the (PM on the day before surgery OR AM on day of surgery)
  - insulin ____________ (other: specify) ________ units SUBCUTANEOUSLY ONCE in the PM on the day before surgery

- Bolus and Correction insulin
  - Take as per your home regimen. Do NOT take bolus insulin when you are not eating/drinking for surgery. You may take correction insulin if your blood sugar is out of target.

Consults/Referrals

Inpatient Specialty Consults
For patients with a Hemoglobin A1C greater than 8.5% or patients with preoperative blood glucose equal to or greater than 10.0 mmol/L, consider a referral to the appropriate services as per hospital/site availability (i.e. Endocrinology, General Internal Medicine, diabetic education program/health care team or Family Physician with diabetes expertise).

- Consult Internal Medicine
- Consult Endocrinology
- Consult Hospitalist
- Consult Family Physician with diabetes expertise
- Consult (other): ________________

Referrals
- Consult/Referral to Diabetes Education Program/Health Care Team (resources as applicable)
Preoperative Management for Patients with Diabetes NOT on Insulin

Order Set - This order set provides instructions for management for patients with type 2 diabetes undergoing surgery and is intended to be completed in the pre-admission clinic for use in the immediate preoperative area on the day of surgery.

Order Set Restrictions: Not for use in patients with type 1 diabetes mellitus, pregnant women with diabetes, patients younger than 18 years of age

Order Set Keywords: Perioperative diabetes management

Order Set Requirements: Weight

Day of Procedure

Diet and Nutrition
Carbohydrate loading is not recommended for patients with diabetes undergoing scheduled surgical intervention requiring anesthesia care. Current available evidence has shown no clear benefit with routine use of carbohydrate loading among patients with diabetes. There is potential harm arising from hyperglycemia in the peri-operative period for this population. The Clinical Knowledge Topic working group recommends against carbohydrate loading in patients with diabetes until prospective trials have been completed in this population.

The minimum duration of pre-operative fasting prior to the administration of anesthesia should be 8 hours after a meal that includes meat or fried or fatty foods, 6 hours after a light meal (such as toast and a clear fluid), 2 hours after clear fluids.

Pre-operative eating and drinking
☑ Clinical Communication: Final snack 8 hours prior to scheduled surgery
☑ Clinical Communication: Clear fluids until

Patient Care

Point Of Care Testing Glucose
☑ Blood Glucose Monitoring POCT: AM of surgery
☐ Blood Glucose Monitoring POCT every ______ hour(s)
☑ Clinical Communication – If blood glucose less than 4.0 mmol/L, and patient is or has been on insulin or secretagogues, initiate Hypoglycemia Procedure
☑ Clinical Communication – If blood glucose is greater than 18.0 mmol/L, initiate Hyperglycemia Procedure and notify Authorized Prescriber
☑ Clinical Communication - If blood glucose is greater than 14.0 mmol/L and on SGLT2 inhibitors, initiate Hyperglycemia Procedure, notify Authorized prescriber and collect ketones

Laboratory Investigations Routine
For Ketone Testing for Suspected Diabetic Ketoacidosis.
☐ Nursing Communication: If patient has symptoms of Diabetic Ketoacidosis order Beta-Hydroxybutyrate if available. Symptoms include but not limited to polyuria, thirst, nausea/vomiting, abdominal pain, weakness, mental status change, recent weight loss, and coma)

Perioperative Management of Patients with Diabetes Mellitus, Adult – Acute Care V 1.0 Page 17 of 30
Conditional Order: Available for nurse to activate if

1. Patient has a blood glucose of greater than 14.0 mmol/L AND on SGLT2 inhibitors medication

Chemistry

- Serum Ketones preferred over Urine Ketones for diagnosis of DKA
- Beta-Hydroxybutyrate

Urine

- If patient has symptoms of Diabetic Ketoacidosis order Beta-Hydroxybutyrate if available
- Urine Ketones
- POCT Urine Ketones Dipstick Urinalysis if available

Medications

Diabetic Agents

Calculated TDD for this order: ________________

When NPO, if Blood Glucose is Greater than 10.0 mmol/L – Use Correction Insulin for Hyperglycemia:

For patients with known home regimen – use custom option to order patient’s usual correction insulin brand and dosing. For patients not on home insulin or unknown home insulin regimen, calculate total daily dose (TDD) of insulin using 0.3 to 0.5 units/kg/day for lower TDD and 0.5 to 1 units/kg/day for higher TDD and choose correction dose below. Patients who are not eating and drinking must still receive basal and correction insulin

Choose ONE

Use the same insulin (rapid or short-acting) for bolus (when eating) and correction

☐ Iispro (HumaLOG®) SUBCUTANEOUSLY PRN for Blood Glucose greater than 10.0 mmol/L
☐ aspart (Novorapid®) SUBCUTANEOUSLY PRN for Blood Glucose greater than 10.0 mmol/L
☐ insulin regular (HumuLIN® R) SUBCUTANEOUSLY PRN for Blood Glucose greater than 10.0 mmol/L

☐ Clinical Communication - Correction dose to be determined and administered with/before meal/enteral feed OR at scheduled mealtime if NPO. Bedtime correction not routinely recommended.
☐ Nursing Communication: Patients who are not eating and drinking must still receive basal and correction insulin

Choose ONE correction insulin (below) based on current Total Daily Dose (TDD)

Use the same insulin (rapid or short-acting) for bolus (when eating) and correction
If TDD is 15-30 units
□ insulin correction SUBCUTANEOUSLY TID with mealtime based on Blood Glucose reading
  • 0 unit if Blood Glucose 4.1 – 10.0 mmol/L
  • 1 unit if Blood Glucose 10.1 – 14.0 mmol/L
  • 2 units if Blood Glucose 14.1 – 18.0 mmol/L

If TDD is 31-50 units
□ insulin correction SUBCUTANEOUSLY TID with mealtime based on Blood Glucose reading
  • 0 unit if Blood Glucose 4.1 – 10.0 mmol/L
  • 1 unit if Blood Glucose 10.1 – 12.0 mmol/L
  • 2 units if Blood Glucose 12.1 – 15.0 mmol/L
  • 3 units if Blood Glucose 15.1 – 18.0 mmol/L

If TDD is 51-80 units
□ insulin correction SUBCUTANEOUSLY TID with mealtime based on Blood Glucose reading
  □ 0 unit if Blood Glucose 4.1 – 10.0 mmol/L
  □ 2 units if Blood Glucose 10.1 – 12.0 mmol/L
  □ 3 units if Blood Glucose 12.1 – 14.0 mmol/L
  □ 4 units if Blood Glucose 14.1 – 16.0 mmol/L
  □ 5 units if Blood Glucose 16.1 – 18.0 mmol/L

If TDD is 81 units or more
□ insulin correction SUBCUTANEOUSLY TID with mealtime based on Blood Glucose reading
  □ 0 unit if Blood Glucose 4.1 – 10.0 mmol/L
  □ 2 units if Blood Glucose 10.1 – 11.0 mmol/L
  □ 4 units if Blood Glucose 11.1 – 13.0 mmol/L
  □ 6 units if Blood Glucose 13.1 – 15.0 mmol/L
  □ 8 units if Blood Glucose 15.1 – 17.0 mmol/L
  □ 10 units if Blood Glucose 17.1 – 18.0 mmol/L

Custom (Known Home Regimen, Post-pancreatectomy, Extreme Insulin Sensitivity or Resistance)
□ insulin correction SUBCUTANEOUSLY TID with mealtime based on Blood Glucose reading
  • ______ units if Blood Glucose ______ – ______ mmol/L
  • ______ units if Blood Glucose ______ – ______ mmol/L
  • ______ units if Blood Glucose ______ – ______ mmol/L
  • ______ units if Blood Glucose ______ – ______ mmol/L
  • ______ units if Blood Glucose ______ – ______ mmol/L

Intravenous Insulin
Subcutaneous insulin is preferred to intravenous insulin when possible. Consider intravenous insulin in patients with diabetes who will miss more than one meal, who have missed their basal insulin dose, patients with a Hemoglobin A1C greater than 8.5% or with patients who present with significant hyperglycemia (based on clinician’s judgement).

If blood glucose is greater than 10mmol/L consideration should be given to continuous or intermittent bolus of IV insulin with blood glucose monitoring every 30-60min, while the patient is in the OR with the goal of keeping the blood glucose between 7-10 (Bhamidipate et al 2011).

Continuous or intermittent IV bolus are superior to SC injections for long cases due to large variations in skin perfusion and therefore absorption during the preoperative period (Kadio et al 2012 and Alexanain et al 2011).

Recommend to transition to SC insulin before leaving the OR or to consult Endocrinology or Internal Medicine to transition if patient transferred to surgical unit on IV insulin, especially in patients with diabetes mellitus type 1

Standard Concentration for Intravenous Insulin - 100 units per 100 mL (IV fluid provides 1 unit/mL). Mix as per AHS provincial Parenteral Monograph

IV insulin titration protocol

- Insulin regular (Humulin ® R) IV infusion in Normal Saline in units/hour. Adjust insulin infusion every 1hour according to blood glucose results – see table below

<table>
<thead>
<tr>
<th>Blood Glucose (mmol/L)</th>
<th>Insulin Dose (units/hour)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 4.0</td>
<td>0 unit and activate Hypoglycemia Protocol</td>
</tr>
<tr>
<td>4.0 - 6.5</td>
<td>0.5 units/hour</td>
</tr>
<tr>
<td>6.6 - 9.0</td>
<td>1 unit/hour</td>
</tr>
<tr>
<td>9.1 - 12.0</td>
<td>2 units/hour</td>
</tr>
<tr>
<td>12.1 - 15.0</td>
<td>3 units/hour</td>
</tr>
<tr>
<td>15.1 - 18.0</td>
<td>4 units/hour</td>
</tr>
<tr>
<td>18.1 - 21.0</td>
<td>5 units/hour</td>
</tr>
<tr>
<td>21.1 - 24.0</td>
<td>6 units/hour</td>
</tr>
<tr>
<td>Greater than 24</td>
<td>8 units/hour</td>
</tr>
</tbody>
</table>

Consults/Referrals

For patients with a Hemoglobin A1C greater than 8.5% or patients with preoperative blood glucose equal to or greater than 10.0 mmol/L, consider a referral to the appropriate services as per hospital/site availability (i.e Endocrinology, General Internal Medicine, diabetic education program/health care team or Family Physician with diabetes expertise).

Inpatient Specialty Consults

- Consult Internal Medicine
- Consult Endocrinology
- Consult Hospitalist
- Consult Family Physician with diabetes expertise

Referrals
Consult/Referral to Diabetes Education Program/Health Care Team (resources as applicable)
Postoperative Management for Patients with Diabetes NOT on Insulin Order Set

Order Set Restrictions: Not for use in patients with type 1 diabetes mellitus, pregnant women with diabetes, patients younger than 18 years of age
Order Set Keywords: Perioperative diabetes management

Post procedure Care

Diet and Nutrition
- Post-Surgical Transition Diet: start on POD 0
- Regular Diabetic – Adult Diet: start on POD 1
- Other diet ______

Patient Care
- Point Of Care Testing Glucose
  - Blood Glucose Monitoring POCT on arrival to unit (Post Anesthesia Care Unit and ward)
  - Blood Glucose Monitoring POCT 4 times per day (15 - 30 minutes before scheduled meals and at bedtime) and PRN for suspected hypoglycemia
  - Blood Glucose Monitoring POCT every ______ hour(s)
- Clinical Communication – If blood glucose less than 4.0 mmol/L initiate Hypoglycemia Procedure
- Clinical Communication – If blood glucose is greater than 18.0 mmol/L, initiate Hyperglycemia Procedure and notify Authorized Prescriber
- Clinical Communication - If blood glucose is greater than 14.0 mmol/L and on SGLT2 inhibitors, initiate Hyperglycemia Procedure, notify Authorized prescriber and collect ketones

Laboratory Investigations Routine
For Ketone Testing for Suspected Diabetic Ketoacidosis.
- Nursing Communication: If patient has symptoms of Diabetic Ketoacidosis order Beta-Hydroxybutyrate if available. Symptoms include but not limited to polyuria, thirst, nausea/vomiting, abdominal pain, weakness, mental status change, recent weight loss, and coma)
  - Conditional Order: Available for nurse to activate if
    1. Patient has a blood glucose of greater than 18.0 mmol/L
    2. Patient has a blood glucose of greater than 14.0 mmol/L on SGLT2 inhibitors medication
- Chemistry
  - Serum Ketones preferred over Urine Ketones for diagnosis of DKA
  - Beta-Hydroxybutyrate

Urine
If patient has symptoms of Diabetic Ketoacidosis order Beta-Hydroxybutyrate if available
Medications
Diabetic Agents
Patients achieving targets of 5.0 - 10.0 mmol/L in hospital diabetes should be transitioned to their home regimen when they are eating and drinking

☐ Continue as per home dosing for insulin, oral and non-insulin injectable anti-hyperglycemic medications (list below):

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

The recommended in-hospital Blood Glucose (BG) target for most patients is 5.0 - 10.0 mmol/L. Patients who do not meet these targets may require insulin, even temporarily, while in hospital. The Basal Bolus Insulin Therapy (BBIT) Order Set should be used. **Patients who are not eating and drinking must still receive basal and correction insulin.** Patients who are eating and drinking will also require bolus insulin. The AHS provincial Glycemic Management policy supports these recommendations.

For IV insulin infusion - If required in ICU, critical units or specialty units with appropriate competency

☐ Nursing Communication: Patients who are not eating and drinking must still receive basal and correction insulin

☐ Continue IV insulin until the first scheduled subcutaneous basal insulin dose

☐ Discontinue the IV insulin 2 hours after the administration of basal (intermediate or long-acting) insulin (IV insulin has duration of action of about 7 minutes).

☐ Basal Bolus Insulin Therapy Order Set

☐ Other medication(s): _________________________________________

Consults and Referrals
Inpatient Specialty Consults
For patients with poor glucose control or patients with preoperative blood glucose equal to or greater than 10.0 mmol/L, consider a referral to the appropriate services as per hospital/site availability (i.e Endocrinology, General Internal Medicine, diabetes education program/health care team or Family Physician with diabetes expertise).

☐ Consult Internal Medicine

☐ Consult Endocrinology

☐ Consult Hospitalist

☐ Consult Family Physician with diabetes expertise

☐ Consult (other): __________________

Referrals

☐ Consult/Referral to Diabetes Education Program/Health Care Team (resources as applicable)
Clinical Decision Support

CDS Calculator Requirements:

- Calculator to determine Total Daily Dose of insulin and then to automatically calculate insulin doses for basal, bolus, and chooses approximate correction insulin doses

**Total Daily Dose (TDD)**

- Calculator to determine total number of all units of basal, bolus, and correction insulin used in last 24 hour period
  - TDD (units) = basal + bolus + correction used in the last 24 hour period

- If TDD from previous day is not available, or weight based calculation required, then use calculator to determine TDD by weight. Use if patient has poor control or requires insulin (even transiently) in hospital to achieve targets of 5.0 - 10.0 mmol/L

  **Use LOWER TDD IF** one or more of the following:

  - Type 1 DM, Slim Type 2 DM, History of hypoglycemia unawareness, Reduced renal function (eGFR less than 30 mL/min), Age greater than 70 with moderate/severe frailty or Liver failure

  **TDD = Weight (kg) x 0.3 to 0.5 units/kg/day**

  **Use HIGHER TDD IF** one or more of the following:

  - Insulin resistance, Overweight Type 2 DM, Steroid treatment or Infection

  **TDD = Weight (kg) x 0.5 to 1 units/kg/day**

**Basal Insulin Dose Calculator**

- Calculator to determine scheduled basal insulin doses
  - Total Basal (units) = TDD x 0.5

**Bolus Insulin Dose Calculator**

- Calculator to determine scheduled bolus insulin doses
  - Total Bolus (units) = TDD x 0.5 divided by 3 (three equal doses with meals or enteral feeds)

**Correction Insulin Dose Calculator**

- Calculator to determine correction insulin doses based on patient’s TDD
  - Refer to Correction Insulin for Hyperglycemia order set component for correction doses based on TDD

**Other CDS Requirements:**

- Diabetes report showing blood glucose results in table format, and calculates the last 24 hours of blood glucose results as a diabetes score, thus alerting any dangerous blood glucose.

- Automatic generic/trade population of insulin type into dose boxes
  - Basal Insulin Types auto populates into:
- Basal – Daily Dose
- Basal – BID Doses boxes
  - **Bolus Insulin and Correction Insulin Types** auto populates into:
    - Bolus Insulin – Dose Per Meal
    - Correction Insulin for Hyperglycemia

**Analytics**

**Analytics – Outcome Measure#1**

<table>
<thead>
<tr>
<th>Name of Measure</th>
<th>Hypoglycemia on the day of surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td>Serum blood glucose less than 4.0 mmol/L, nursing documentation of POCT less than 4.0 mmol/L (in clinical flows), activation of the Hypoglycemia Order Set, MPR Document titled &quot;Hypoglycemia&quot; all on the date of surgical procedure.</td>
</tr>
<tr>
<td>Rationale</td>
<td>Hypoglycemia is an important safety outcome when tightening glycemic control.</td>
</tr>
<tr>
<td>Notes for Interpretation</td>
<td>Each patient should only have one event per day. A hypoglycemic event will count before a hyperglycemic event such that if a patient has both events in the same day, only the hypoglycemic event will be counted. This is because the treatment for hypoglycemia often results in hyperglycemia, and a patient undergoing treatment for hypoglycemia often has multiple recorded POCT with low blood sugars.</td>
</tr>
</tbody>
</table>

**Baseline Analytics – Outcome Measure#2**

<table>
<thead>
<tr>
<th>Name of Measure</th>
<th>Hyperglycemia on day of surgery.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td>Serum blood glucose or point of care testing 10.1 mmol/L - 14.0 mmol/L (mild), 14.0 -18.0 mmol/L (moderate) or greater than 18.0 mmol/L (severe) on the day of surgery.</td>
</tr>
<tr>
<td>Rationale</td>
<td>Use of the order sets are intended to reduce postoperative dysglycemia. This outcome is associated with adverse events.</td>
</tr>
</tbody>
</table>
**Baseline Analytics – Outcome Measure#3**

<table>
<thead>
<tr>
<th>Definition</th>
<th>The number of procedures that are cancelled or postponed on the day of surgery due to hypoglycemia or hyperglycemia.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rationale</strong></td>
<td>Surgery cancellations due to implementation of this order set are important.</td>
</tr>
<tr>
<td><strong>Notes for Interpretation</strong></td>
<td>Each patient should only have one event per day. A hypoglycemic event will count before a hyperglycemic event such that if a patient has both events in the same day, only the hypoglycemic event will be counted. This is because the treatment for hypoglycemia often results in hyperglycemia, and a patient undergoing treatment for hypoglycemia often has multiple recorded POCT with low blood sugars.</td>
</tr>
</tbody>
</table>

**Baseline Analytics – Outcome Measure#4**

<table>
<thead>
<tr>
<th>Name of Measure</th>
<th>Hyperglycemia on postoperative day one.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>Serum blood glucose or point of care testing 10.1 mmol/L - 14.0 mmol/L (mild), 14.0 -18.0 mmol/L (moderate) or greater than 18.0 mmol/L (severe) on postoperative day 1</td>
</tr>
<tr>
<td><strong>Rationale</strong></td>
<td>Use of the order sets are intended to reduce postoperative dysglycemia. This outcome is associated with adverse events.</td>
</tr>
</tbody>
</table>
References


Additional General References


### Additional Readings and Resources


**AHS Glycemic Management Policy – Adult**

**Basal Bolus Insulin Therapy Website**

**Diabetes Canada Clinical Practice Guidelines**

Insulin Pump In-Hospital Therapy – [ipumpit.ca](http://www.bbit.ca/assets/ahs-scn-don-guide-to-surgical-diabetes-management.pdf)

### Relevant Clinical Knowledge Topics

Basal Bolus Insulin Therapy, Adult - Inpatient (BBIT)
Insulin Pump Therapy, Pediatric and Adult – Acute Care
Glycemic Management
Enhanced Recovery for all Surgeries, Adult – Inpatient
ERAS Colorectal Surgery, Adult – Inpatient
ERAS Cystectomy Surgery, Adult - Inpatient
ERAS Gynecologic Oncology Surgery, Adult – Inpatient
ERAS Liver Surgery, Adult – Inpatient
ERAS Pancreas Surgery, Adult – Inpatient
Acknowledgments

We would like to acknowledge the contributions of the Provincial Clinical Knowledge Working Group members as follows. Your participation and time spent is appreciated.

Appropriate Use of Antipsychotics, Adult – Inpatient Knowledge Topic Working Group Membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Zone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Knowledge Lead</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Benjamin Sugars</td>
<td>Provincial Clinical Knowledge Lead- Medicine</td>
<td>Provincial</td>
</tr>
<tr>
<td>Dr. Eliana Castillo</td>
<td>Provincial Clinical Knowledge Lead- Medicine</td>
<td>Provincial</td>
</tr>
<tr>
<td><strong>Topic Lead</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Shannon Ruzycki</td>
<td>Provincial Clinical Topic Lead</td>
<td>Provincial</td>
</tr>
<tr>
<td><strong>Working Group Members</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Leah Gramlich</td>
<td>Physician</td>
<td>Edmonton</td>
</tr>
<tr>
<td>Dr. Colin MacDonald</td>
<td>Physician</td>
<td>Edmonton</td>
</tr>
<tr>
<td>Dr. Tammy McNab</td>
<td>Physician</td>
<td>Edmonton</td>
</tr>
<tr>
<td>Dr. Rany Al-Agha</td>
<td>Physician</td>
<td>Edmonton</td>
</tr>
<tr>
<td>Dr. Julie McKeen</td>
<td>Physician</td>
<td>Calgary</td>
</tr>
<tr>
<td>Dr. Karmon Helmle</td>
<td>Physician</td>
<td>Calgary</td>
</tr>
<tr>
<td>Dr. Anna Cameron</td>
<td>Physician</td>
<td>Calgary</td>
</tr>
<tr>
<td>Dr. Adeel Azam</td>
<td>Physician</td>
<td>South</td>
</tr>
<tr>
<td>Dr. Judy Marois</td>
<td>Physician</td>
<td>North</td>
</tr>
<tr>
<td>Leta Philp</td>
<td>Clinical Practice Lead DON SCN</td>
<td>Provincial</td>
</tr>
<tr>
<td>Lorelei Domaschuk</td>
<td>Provincial IPT Program Coordinator</td>
<td>Central</td>
</tr>
<tr>
<td>Kevin Iwaasa</td>
<td>ERAS Nurse</td>
<td>South</td>
</tr>
<tr>
<td>Katrina Percival</td>
<td>ERAS Nurse</td>
<td>Edmonton</td>
</tr>
<tr>
<td>Christine Fantuz</td>
<td>ERAS Nurse</td>
<td>Calgary</td>
</tr>
<tr>
<td>Joy Hatton</td>
<td>Patient Safety Practitioner</td>
<td>Edmonton</td>
</tr>
<tr>
<td>Alison Nelson</td>
<td>ERAS Lead</td>
<td>Provincial</td>
</tr>
<tr>
<td><strong>Clinical Support Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stacey Ginther &amp;</td>
<td>on behalf of Pharmacy Information Management</td>
<td>Provincial</td>
</tr>
<tr>
<td>Rhonda Roedler</td>
<td>Governance Committee (PIM-GC) - Pharmacy Services</td>
<td></td>
</tr>
<tr>
<td>Dr. Bill Anderson</td>
<td>On behalf of Provincial Diagnostic Imaging</td>
<td>Provincial</td>
</tr>
<tr>
<td>Dr. James Wesenberg</td>
<td>On behalf of Laboratory Services – Provincial Networks</td>
<td>Provincial</td>
</tr>
<tr>
<td>Melanie Gillam</td>
<td>On behalf of Provincial Nutrition and Food Services</td>
<td>Provincial</td>
</tr>
<tr>
<td><strong>Strategic Clinical Network</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes, Obesity, Nutrition Strategic Clinical Network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery Strategic Clinical Network</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Informatics Lead</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leng My</td>
<td>Provincial</td>
<td></td>
</tr>
</tbody>
</table>
Additional Contributors

Thank you to all provincial stakeholders who participated in the review process for this topic. Your time spent reviewing the knowledge topics and providing valuable feedback is appreciated.

For questions or feedback please contact ClinicalKnowledgeTopics@ahs.ca.