Review a minimum of **10** and a maximum of **20** medical records.

Focus:

For this review, review randomly selected charts of inpatients (e.g., the last 10) who had a blood glucose below the reporting threshold (e.g., > 50 mg/dL)) drawn at any time during the hospital stay. Do not include charts where the low blood glucose was drawn in the ED on the day of admission.

Instructions:

When reviewing the medical record, if documentation is found for the process, mark "**Yes**" in the box. If documentation is not found for the process, mark "**No**". If the process being reviewed is not applicable to the medical record, mark "**N/A**". After completing the review of all records, note the rows with the highest number of "*No*" responses. This will identify priority focus areas for improvement.

Note: Do not spend more than 20-30 minutes per medical record.

SUBMIT YOUR DISCOVERY TOOL FINDINGS WHEN COMPLETE: Take a 2 minute survey to report your findings. By submitting your findings, you will have taken the time to identify process gaps in which to focus improvement and to guide educational activities.

CLICK HERE TO SUBMIT YOUR FINDINGS

Medical Record #										
Target glucose is 140 – 180 mg/dL.										
If Glucose < 100 occurred, the insulin regimen was reduced. Otherwise "N/A"										
If Glucose < 70 occurred, the insulin regimen was reduced. Otherwise "N/A"										
Patient was receiving basal insulin.										
Patient eating **AND** receiving bolus insulin.										
Patient was **NOT** receiving Sliding Scale Insulin alone.										
If sudden loss of parenteral glucose occurred, it was managed promptly through standing nursing orders. **SEE NOTE BELOW										
If sudden NPO occurred, it was managed promptly through standing nursing orders. **SEE NOTE BELOW										
If sudden loss of appetite occurred (includes nausea, vomiting, etc) it was managed promptly through standing nursing orders. **SEE NOTE BELOW										
Home dietary intake and insulin regimen were evaluated on admission and insulin doses were reduced as appropriate for expected lower carb intake in hospital.										
Documentation exists showing appropriate meal-insulin coordination. (insulin within 15 minutes before or after meal delivery to patient)										
There is evidence that (1) insulin management in the hospital was discussed with the patient, (2) how it is different from home care, **AND** (3) that the patient understood the how to get help should their glucose levels drop below 70 mg/dL. (Y/N)										
If the patient's glucose was managed at home with a system that included an insulin pump and a continuous glucose monitor (CGM), the patient was allowed to continue to use those system and actively be involved in their glucose management as allowed by hospital policy. (Y/N/NA) **NOTE:** If the patient was on a pump and a CGM and no hospital policy exists, enter N										
Other (specify)										

Hypoglycemia Discovery Tool

(Stated in the positive/rows with blanks mean best practices are absent)

- Target glucose less that 140 mg/dL. (clue: look for correction scales where insulin given if < 150 mg/dL)
- If the glucose dropped below 100 mg/dL at any time, the insulin regimen was changed.
- If the glucose dropped below 70 mg/dL at any time, the insulin regimen was changed.
- Patient received daily basal insulin. (N/A if in ICU on insulin drip)
- If eating, the patient received prandial doses of insulin. (also called nutritional or bolus insulin)
- The patient was not managed with sliding scale insulin as the sole method of glycemic control.
- If the patient had a sudden loss of parenteral glucose, nurse driven standing orders were implemented.
- If the patient was suddenly and without warning made NPO, nurse driven standing orders were implemented.
- If the patient has sudden loss of appetite, nurse driven standing orders were implemented.
- There is evidence that the home dietary and insulin needs were evaluated by the physician upon admission and that appropriate changes (typically reductions) were made in the home insulin regimen upon admission.
- There is evidence that insulin administration and meal delivery were coordinated such that there was no more than a 15-minute lag between insulin administration and meal deliver, or vice versa.

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