UCSF Medical Center

UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION DATE

OB GUIDELINES FOR USING YOUR SUBCUTANEOUS INSULIN PUMP WHILE IN THE HOSPITAL

While you are in the hospital, it is the hospital staff's responsibility to ensure that your blood sugars are controlled as well as possible. The decision that you will remain on the insulin pump in the hospital will be determined by your medical team in consultation with the endocrine service as well as our medical status. It is against hospital policy and state regulations to keep insulin vials at the bedside and to use insulin from home. You will be asked to change your pump reservoir and infusion set (using your own supplies) and use a new bottle of insulin (will be supplied by the hospital pharmacy).

Your responsibilities:

1. Bring all the supplies needed for use of your pump. Include extra infusion sets, reservoirs and batteries. EXCEPT insulin.
2. Change the infusion site at least every 48 hours while hospitalized. You will need to do this sooner than 48 hours if you experience unexplained hyperglycemia (repeated blood sugar greater than 250mg/dL) or if there are signs of infection at the insertion site.
3. Show the nurse the settings on your pump whenever he/she requests.
4. Disconnect from your pump for mammograms,bone density tests, radiation treatment, CT scan, MRI,and x-rays. The infusion set can remain in place.
5. Do not change pump settings without MD direction and RN supervision.
6. Do not give boluses without RN supervision.

Responsibilities of the nurse caring or you:

1. Check infusion site for redness or dislodgement of the infusion catheter.
2. Verify and record your pump's basal rate, carbohydrate ratio, and correctional insulin dose at least each shift.
3. Verify that the pump reservoir has enough insulin for 24 hours.
4. Treat high and low blood sugars:
   a. If your blood sugar is greater than 250mg/dL x 2, you will be asked to change our infusion set and insulin will be given by injection to correct your high glucose.
   b. If your blood sugar is less than 70mg/dL, you will be given 20 grams of carbohydrate by mouth. If you are not alert enough to swallow safely, you will be given glucose intravenously.
5. Supervise your boluses of insulin.
6. Report to Physician if patient is not meeting the responsibilities as outlined above.

Indications for removing or disconnecting the pump:

1. It may be necessary to remove or discontinue your insulin pump for the following situations:
   a. Pump malfunctions, set dislodges or kinks, or reservoir becomes empty and you are unable to correct the problem by changing the insulin reservoir.
   b. If you become unconscious due to suspected hypoglycemia.
   c. If the healthcare team thinks you are unable to operate your pump safely.
   d. If your blood glucose levels are not stable.
   e. If you are scheduled for certain procedures such as x-rays.
   f. If you go into active labor or require a cesarean section.

Informed Consent/Waiver of Liability

I hereby request that the University of California at San Francisco Medical Center(UCSF Medical Center) make available to me my own insulin until I am able to switch my pump reservoir to insulin supplied by the hospital pharmacy. I understand that my own medication can not be identified and verified as to type of insulin, previous storage or expiration date. It is the policy of UCSF Medical Center to clearly identify all medications provided by a patient before they may be administered in the hospital. I understand that UCSF Medical Center staff cannot verify the contents in my insulin pump and understand that this may present risks to my health, including but not limited to hyperglycemia, Diabetic Ketoacidosis, hypoglycemia, and infection.

I release UC and its employees from any liability regarding my use of the insulin pump during my hospitalization, including but not limited to damage, loss, theft and malfunction.

I understand that my physicians and other health care providers have the right to terminate my use of the insulin pump should they observe any contraindication to its use or for any reason they believe medically necessary.

My signature below is my acknowledgement that I have read, understood, and agreed to the above.

Patient's Signature _____ Date ___ / ___ / _____

Physician Signature _____ Date ___ / ___ / _____

Witness Signature_____ Date ___ / ___ / _____

107-0042 (Rev. 11/09) WorkflowOne MEDICAL RECORD COPY