SHARP
San Diego's Health Care Leader

Attachment A

Patient Insulin Pump Questionnaire

Patient safety is a primary concern at Sharp HealthCare. For you to continue with the use of your insulin pump while in hospital you must demonstrate that you are able to independently self-manage your pump and insulin requirements. If you are **unable** to answer any of the questions below your physician will be contacted and alternate insulin delivery may be necessary.

1. The brand of my insulin pump is:

☐ MedtronicParadigm ☐ Omni Pod ☐ Animas ☐ Coz More ☐ Accu-Chek Spirit ☐ Other _____

The Serial Number of my Insulin Pump or PDM (Omni pod only) is _____

2. The type of Insulin I use is:

☐ Humalog (Lispro) ☐ Novolog (Aspart) ☐ Apidra (Glulisine) ☐ Regular ☐ Highly Concentrated U-500 Insulin

3. My infusion site is currently located on _____ (body area)

4. I last changed my site and infusion set on _____ (date)

5. Who changes your site and infusion set? _____

6. I have brought the following insulin pump supplies with me:

	YES	NO		YES	NO
Insulin			Tape (i.e.Tegaderm, IV 3000)		
Batteries			Blood Glucose Meter		
Reservoir / Cartridge			Blood Glucose Strips		
Infusion set w/tubing			Skin prep		

7. My Personal Blood Glucose goals: Fasting _____ before meals _____ Bedtime _____

8. My Basal Rates are:

TIME	Insulin Units/ Hour
12:00 AM TO _____	
_____ TO _____	
_____ TO _____	
_____ TO _____	

9. I give the following insulin dose with each meal:

MEALS	Insulin Units/ Grams of Carbohydrate
BREAKFAST	
LUNCH	
DINNER	
SNACKS	

10. One (1) unit of insulin will lower my blood glucose _____ points

11. I give meal boluses with (check all that apply):
A. Standard bolus ___ B. Dual wave bolus___
C. Square wave bolus___ D. Other meal bolus___

Patient Identification

Patient Signature: _____ Date/Time: _____
Family/Guardian Signature: _____Date/Time: _____
RN Signature: _____Date/ Time: _____

Place in the chart when completed. To be scanned as part of permanent records.

Attachment B

PATIENT INSULIN PUMP THERAPY AGREEMENT

Pump therapy is a form of diabetes self-management not commonly used in a hospital setting due to hospital liabilities, training required to use a pump and changes that may affect patient ability to use the pump in a hospital setting. Sharp HealthCare respects your wish to maintain tight control through the use of your pump, but must ensure that your treatment is both safe and effective. Please read the guidelines below and sign that you agree to comply with the following hospital requirements.

It is my responsibility to:

- Notify the nurse and complete the Insulin Pump Flow Sheet each time I give myself a bolus
- Show the nurse my basal rate(s) and comply with changes in the basal rates made by the doctor
- Maintain the Insulin Pump Flow Sheet, keeping it current with self-treatment
- Change the infusion set and site every 48-72 hours or as needed for skin irritation or two consecutive (in a row) blood sugar readings greater than 240 mg/dL
- Provide my own insulin pump supplies, including insulin, x3 insertion sets, pods, etc.
- Report signs/symptoms of low blood sugar to the nurse
- Report to the nurse any pump problems or suspected malfunction
- Check the insulin pump to make sure there is enough insulin for the day and document the amount on the flow sheet
- Document my blood sugar results a minimum of 4-6 times per day or per doctor's order

The nurse will:

- Treat low blood sugar by providing snacks as needed or glucose per hypoglycemia protocol
- Call doctor for alternate insulin delivery order if indicated
- Check Infusion site every shift for redness or swelling
- Perform all blood sugar testing using the Hospital glucometer at least before meals, bedtime and 02:00 or every 4 hours if not eating.

Other Information:

I understand that my **pump may be discontinued** and a different method of insulin delivery given to me for any of the following:

- Changes in my judgment, level of awareness or consciousness
- Inability to fully cooperate with my healthcare team's medical recommendations
- Any radiology/electromagnetic procedure that requires removal of the pump
- Failure to bring in ALL of my own pump supplies, x3 insertion sets, pods, insulin etc.
- An adverse event related to suspected pump malfunction. Should this occur, SHC will sequester the pump to evaluate the device per P&P # 06010.99, Defective Medical Devices.
- If caregiver is unable to stay 24hr/day and is overseeing the management of my pump

I have reviewed and agree to comply with all the above specifications in order to continue the use of my insulin pump in the hospital setting. I agree to be an active participant and will conform to the hospital requirements. In the event that my physician and healthcare team determine a change has occurred that interferes with my ability to use the pump it will be discontinued and an alternative insulin delivery method implemented. I agree to fully cooperate with my healthcare team recommendations and understand this is for my personal safety and recovery.

Patient Identification

Patient's Signature_____Date/Time _____
Family/Guardian Signature:
RN's Signature_____Date/Time_____

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Bedside Subcutaneous Insulin Pump Flow Sheet

Patient to complete daily.

Date: _____

INSULIN (Select One): Aspart (Novolog®) _____ Glulisine (Apidra®)_____ Lispro (Humalog®)_____ Regular (Novolin®)_____ U500 Insulin_____

	6AM	7AM	8AM	9AM	10AM	11AM	12PM	1PM	2PM	3PM	4PM	5PM
Blood Sugar												
Grams Carbohydrates												
Total Bolus												
Basal Hourly Rate												
	6PM	**7PM**	**8PM**	**9PM**	**10PM**	**11PM**	**12MN**	**1AM**	**2AM**	**3AM**	**4AM**	**5AM**
Blood Sugar												
Grams Carbohydrates												
Total Bolus												
Basal Hourly Rate												

Site Change: Yes____ No____ **New Site Location: _____**

Comments:

Pt. Signature:

(Patient/Parent/Conservator/Guardian)

Reviewed by RN _____Date/Time: _____

Reviewed by RN _____Date/Time: _____

Reviewed by RN _____ Date/Time: _____

Patient Identification

Place in the chart when completed. To be scanned as part of permanent records.