

It is the responsibility of every individual to ensure this is the latest version as published on the Trust Intranet

GUIDELINE FOR MEMBERS OF THE MULTI DISCIPLINAR DIABETES TEAM WHO ARE NOT PRESCRIBERS FOR ADVISING ON INSULIN DOSE ADJUSTMENT AND TEACHING THE SKILLS OF INSULIN DOSE ADJUSTMENT TO ADULTS WITH TYPE 1 OR TYPE 2 DIABETES MELLITUS AND GESTATIONAL DIABETES

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

People with diabetes who are treated with insulin are encouraged to self-manage their diabetes by making systematic changes to their insulin doses. Registered Dietitians (RD) and Diabetes Specialist Nurses (DSN) and Diabetes Specialist Midwives (DSM) have a key role in educating people with diabetes how to make these adjustments safely.

These professionals also have a role in advising on appropriate dose adjustments in an outpatient setting. This guideline is aimed at giving consistent advice to adults with diabetes in Worcestershire and to support RDs and DSNs when advising adults on their caseload on insulin dose adjustment. The guideline includes advising on insulin dose adjustment and teaching people self-management skills of insulin dose adjustment in an inpatient, outpatient or group education setting. The guideline covers people with type 1 and type 2 diabetes mellitus and those with gestational diabetes. Dietitians would not be advising on specific dose adjustments for inpatients. Diabetes nurses may make recommendations to the prescriber but would not alter the inpatient prescriptions themselves. For all people the GP, inpatient medical team, or DSN with independent prescribing qualifications would be responsible for prescribing the insulin. This guideline may also help prescribers who need further guidance on how to adjust insulin safely in diabetes. management

This guideline is for use by the following staff groups:

- Diabetes Specialist Nurses who do not possess a non-medical prescribing qualification that has been registered with the Trust NMP lead.
- Specialist Diabetes Dietitians
- Diabetes Specialist Midwives.
- The guideline can also be used by prescribers to assist them with decision making when needing to adjust insulin especially in the absence of the diabetes team.

Lead Clinician(s)
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Senior Diabetes Specialist Dietitian
Lead Nurse for Diabetes

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Approved by [Diabetes Directorate Meeting] on: 3rd November 2025

Approved by Medicines Safety Committee on: 8th April 2026
Where medicines are included in document.

Review Date: 3rd November 2028

This is the most current document and should be used until a revised version is in place

Key amendments to this guideline

Date	Amendment	Approved by:
March 2014	New document	Diabetes Directorate
August 2016	Updated with new insulins	Diabetes Directorate
March 2019	Updated with new insulins and in line with new DAFNE curriculum regarding blood glucose targets and managing physical activity	Diabetes Directorate
June 2019	Document extended for 6 months whilst review and approval in process	Diabetes Directorate
31st July 2020	No amendments made to document	Diabetes Directorate
July 2023	Updated with new insulins and to reflect changes to continuous glucose monitoring and hybrid closed loop insulin pumps	Diabetes Directorate
November 2025	Slight change of wording to title of the guideline Patient groups expanded to cover women with gestational diabetes Staff groups expanded to cover new roles such as Diabetes Specialist Midwives and Perioperative Diabetes Specialist Nurse Updated with new insulins and discontinued insulins removed. Removal of reference to the Insulin Care Pathway as this is no longer in use. Include prescribers who might find the guideline useful to aid decision making when needing to adjust insulin doses. Inclusion of VICTOR patient education course Inclusion of electronic record systems - EPR Badgernet and Diamond	Diabetes Directorate

Competencies Required

DSNs working within the diabetes team.

DSM working with women who have gestational diabetes

RDs band 6 and above with a recognised role and experience in the field of diabetes.

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It is expected that the above staff will have understanding of;

- Normal glucose metabolism
- The time action profile of various types of insulin
- The effect of food and digestion on glucose levels of people who require insulin.
- The action of oral hypoglycaemic agents and incretin mimetics on glucose levels.

They will also have skills in;

- Education to people on carbohydrate counting and insulin dose adjustment
- Interpretation of glucose results within the context of the person with diabetes's lifestyle
- Sharing knowledge of other aspects of diabetes care in regard to insulin (physical activity, alcohol, injection site rotation, injection technique, needle length, device use).

Each practitioner is responsible for ensuring their knowledge and skills are kept up to date and training attended as relevant.

- The Trust e-learning on the safe use of insulin must have been completed.
- Additional training will have been completed in insulin pump therapy before advising on insulin dose adjustment for people using an insulin pump.

The competency frameworks for dietitians and nursing staff produced by Diabetes UK in 2011 and 2015 should also be referred to (see references page 11).

PART 1 - Principles of the Guideline

This guideline applies to adults with Type 1 diabetes mellitus, Type 2 diabetes mellitus or gestational diabetes mellitus. requiring insulin excluding people who are unable to interpret instructions and/or give the doses recommended.

- Dose changes are often expressed as 10-20%. This is for clinician guidance and should be expressed as a number of units when giving instructions to people with diabetes.
- To avoid insulin errors 'units' should always be written in full and not abbreviated to 'u'. Also a range should be written in full eg. 1 to 2 units, not 1-2.

1. Description of treatment

- Each person will be assessed individually and recommendations tailored according to their food preferences, lifestyle and physiological requirements. The role of this document is to provide staff with adequate structure to support their role in recommending insulin dose adjustments to people with diabetes treated with insulin. It will enable the person to be empowered to take control of their own diabetes when shown how to adjust doses to meals safely. The process will ensure people are assessed and treated effectively and efficiently and that a high standard of care is maintained and delivered at all times.
- This guideline authorises a Registered Dietitian working in the diabetes service or Diabetes Specialist Nurse or Diabetes Specialist Midwife to make insulin dose recommendations to people with diabetes in order to:
 - Match food boluses more closely to meals to resolve post-meal hyper and hypoglycaemia.
 - Improve diabetes control overall by adjusting basal and mixed insulin doses.
 - Minimise hypoglycaemia / risk of hypoglycaemia through food and eating, alcohol, physical activity and insulin dose adjustment.

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Adjustment to insulin already prescribed to the person with diabetes and covered by this document will include:

	Human	Analogue
Mixtures	Humulin M3®,	Novomix 30®, Humalog Mix 25®, Humalog Mix 50®
Intermediate/ Long acting	Humulin I®,	Lantus®, Levemir®, Tresiba®, Abasaglar®, Toujeo®, Semglee®
Quick acting	Actrapid®, Humulin S®,	NovoRapid®, Humalog®, Apidra®, Fiasp®, Lyumjev®, Trurapi®, Admelog®

Adjustments to insulin doses may include a range of dose suggestions for human/analogue insulin and basal insulin depending on whether the goal of care is to minimise hypo/hyperglycaemia or improve diabetes control.

- Dose recommendations are expected to be small for people who are sensitive to insulin (i.e. 1 to 2 units).
- Dose recommendations are expected to be higher for people, who are not sensitive to insulin, e.g. people with Type 2 diabetes mellitus or who are overweight.
- People with type 1 and type 2 diabetes mellitus have very differing needs in terms of education and insulin requirements. This needs to be taken into account when advising on insulin dose adjustment.

2. Glucose monitoring

- Glucose targets need to be individually tailored to the individual person with diabetes taking account of usual glucose control, frequency and awareness of hypoglycaemia, presence of complications of diabetes etc. Rapid improvements in control should be avoided.
- NICE target for HbA1c 48mmol/l (Type 1 and Type 2 diabetes), (although this may be individualised and set higher for specific people)
- Glucose targets- general 5-7mmol/l before meals
- It is often advisable to aim for slightly higher glucose readings before bed and the DAFNE glucose targets may be useful for many people with diabetes.
 - Before breakfast 5-7 mmol/l
 - Before other meals 4-7 mmol/l
 - Before bed 5-9 mmol/l
- In pregnancy glucose targets are lower and the targets are
 - Fasting 4 - 5.2 mmol/l
 - Before other meals 4 – 5.2 mmol/l
 - 1 hour after eating 4 – 7.7mmol/l
 - Before bed 4.0 – 5.2 mmol/l

Insulin dose adjustment should be based on trends in glucose not one off readings. Capillary BG meters are only accurate to within 15%. Flash and continuous glucose monitoring (CGM) is used by most people with type 1 diabetes and an increasing proportion of people with type 2 diabetes using insulin. They should confirm this with a capillary BG if symptoms do not match the flash/CGM result.

3. Records

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- People should receive written confirmation and express verbal agreement with advice recommended at the time of their appointment (Written confirmation is not possible with telephone consultations but people should be asked to repeat back the advice to confirm understanding). A note of recommended doses in their monitoring diary or on their diet sheet is adequate.
- A summary of the clinic visit (including dose decisions) will be placed in the Trusts dietetic or DSN notes or DIAMOND or Badgernet and a letter will be sent to the referrer.
- If a DSN is advising for an inpatient they will document in the Trust's EPR system.
- After attending X-PERT insulin, VICTOR or DAFNE a letter will be sent to the GP highlighting that the person with diabetes may be self-adjusting doses.

4. Clinical Supervision

1. It is the responsibility of the professionals covered by this policy to seek clinical supervision on an on-going basis and to discuss any specific people who deviate from this guideline.
2. Clinical supervision should be obtained from the:
 - Consultant Diabetologist
 - Senior DSN and
 - Senior Specialist Diabetes Dietitian
3. Clinical supervision can occur at team meetings or on a 1:1 basis as required.

5. Inpatients

- Dietitians will not advise on insulin dose adjustments to be made during the inpatient period. They may educate an inpatient on self-management and dose adjustment following discharge.
- Diabetes nurses without a non-medical prescribing qualifications will not alter inpatient prescriptions but may make recommendations to the prescriber.
- Any advice/ recommendations will be documented in the patients' medical notes.

PART 2 - Guidance For Diabetes Specialist Nurses And Registered Dietitians Adjusting Insulin Doses

The RD/ DSN should encourage people with diabetes to use a systematic approach to analysing their glucose. The following is the stepwise approach encouraged on the DAFNE course and it can be applied to others.

1. identify the problem?
 - Which glucose is out of target?
2. What are the possible causes of the problem?
 - Exclude causes such as carbohydrate estimation, snacks, alcohol, exercise, overtreatment of hypoglycaemia
3. Wait at least 48 hours to look for patterns
 - Unless hypoglycaemic episodes occur overnight when a change should be made without waiting for a pattern
4. Which insulin(s) may be responsible?
 - Review the action profile of the insulin(s)
5. Adjust the responsible insulin as below
6. Review glucose over at least the next 48 hours to ensure that the insulin dose change was appropriate

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Adjusting Meal Insulin Doses

The dose of insulin a person gives for a meal should take into account a number of factors:

- What type of insulin regimen is used (BD, TDS or MDI and the effect of basal insulin at meal times).
- Insulin sensitivity.
- Pre meal glucose.
- Total amount of carbohydrate in the meal (i.e. 3 egg-sized potatoes = 30g CHO needs less insulin for meals than 100g of pasta = 70g CHO).
- Digestion (based on total carbohydrate and other meal factors such as fat, fibre, protein in slowing digestion).
- Secondary digestive disorders (gastroparesis, enteral feeding, coeliac disease)
- Physical activity – pre or post meal.
- Alcohol.
- Injection technique and timing of dose (overuse of sites leads to unpredictable absorption of insulin dose).
- Likelihood of pre-meal glucose being affected by hypoglycaemia or rebound hyperglycaemia.

Basal bolus regimen/ multiple daily injections (MDI)

Adjusting analogue quick acting insulin (NovoRapid®, Humalog®, Apidra® Fiasp®, Lyumjev®, Trurapi®, Admelog®)

- Usually with type 1 diabetes mellitus 1 unit of quick acting insulin for every 10g carbohydrate is a good starting place. People with type 2 diabetes mellitus often require more insulin and an accurate insulin to carbohydrate ratio may not be able to be established. Carbohydrate awareness may be more appropriate than carbohydrate counting for many people with type 2 diabetes mellitus.
- Review food diary/ assess carbohydrate intake and glucose to confirm whether insulin doses need adjustment.
- Dose adjustments should be based on trends in glucose results and not one off readings.
- If glucose is high before lunch increase breakfast insulin. If glucose is high before evening meal increase lunch insulin and if glucose is high before bed increase evening meal insulin.
- If glucose is low before lunch reduce breakfast insulin. If glucose is low before evening meals reduce lunch insulin and if glucose is low before bed reduce evening meal insulin.
- Different insulin to carbohydrate ratios may exist across the day. It is typical to need more insulin at breakfast time due to the dawn phenomenon.
- Increase or decrease quick acting insulin by 0.5 units to 10g carbohydrate (or 2-5g carbohydrate per unit of insulin) for one mealtime only initially.
- An 'average' person with type 1 diabetes mellitus will require 1 unit of quick acting insulin for 10g carbohydrate and approximately 24 units of basal insulin. Often (but not always) roughly half the insulin dose tends to be quick acting and half basal depending on carbohydrate intake. Hybrid closed loop users often need less basal and stronger carbohydrate ratios.

Giving additional 'correction doses' (type 1 diabetes mellitus)

- Additional quick acting insulin may be given at mealtimes to correct for high glucose.

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- Initially assume 1 unit of quick acting insulin will reduce glucose by 2-3mmol/l and monitor the effects.
- Initially give a maximum of 4 units as a correction whilst specific sensitivity is established.
- 'Corrections' should not be given between meals or closer than 3 hours apart unless sick day rules advice is being followed.
- If corrections are regularly required, then insulin to carbohydrate ratio may need to be recalculated.
- Corrections may be given safely at bedtime provided
 - Basal insulin doses are correct (glucose stable between bedtime and pre breakfast)
 - In the absence of alcohol and physical activity
 - Bedtime is at least 3-4 hours after the evening meal/previous dose of quick acting insulin
 - The person with diabetes understands their insulin action
- Corrections pre bed should be recommended with great caution in people with diabetes on steroid therapy, impaired renal function, and over the age of 70 as glucose levels tend to fall rapidly overnight in these groups.
- A similar approach to the above can be used with caution in type 2 diabetes mellitus. Larger insulin doses may be required.

Adjusting Basal Insulin

(Lantus®, Levemir®, Tresiba®, Humulin I®, Abasaglar®, Toujeo®, Semglee®)

If background insulin dose is correct then fasting glucose levels will be similar to pre bed glucose (within 1-2mmol/l)

Hyperglycaemia: If the trend is for glucose to increase overnight, basal insulin may need to be increased by 10-20%. This increased dose should be maintained for 3 days before further dose increases (of 10-20%). With Tresiba® and Toujeo it is more appropriate to wait for 5 days before further increasing the dose. This applies in the absence of ketones or need for sick day rules. In the presence of ketones, dose increases may be suggested as per WHAT-END-001 'Guideline for the Treatment of Diabetic Ketoacidosis'. With type 2 diabetes on larger doses of insulin it may be advisable to increase doses in increments less than 10% of the usual dose.

- If on once daily basal insulin taken in the morning, consider whether the insulin may not be lasting 24hours. In which case an increase in dose will not be appropriate. Consider a change to BD basal insulin eg Levemir® or an ultralong acting insulin such as Tresiba® or Toujeo®.
- A 3am glucose test should be advised to rule out the possibility of nighttime hypoglycaemia before an increase in basal insulin is made. People using flash or CGM should review the patterns overnight to rule out overnight hypoglycaemia and confirm any hypoglycaemia with a capillary glucose test.

If **hypoglycaemia** is verbally described or recorded in a glucose diary/ flash/ CGM (nocturnal or dawn hypoglycaemia) basal insulin should be reduced by 20%. If the trend is for glucose pre breakfast to be more than 1 or 2 mmol/l lower than pre bed, or if bedtime snacks are regularly required then basal insulin should be reduced by 10-20%.

- Typically a person with type 1 diabetes mellitus with a healthy BMI will require around 24 units of basal insulin. People with type 2 diabetes mellitus may require substantially more.

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- If people have to snack to prevent hypoglycaemia, insulin doses need to be reduced.
- When basal insulin doses are reduced quick acting insulin may need to increase- often in line with more accurate carbohydrate counting.

Once daily insulin regimens

(Lantus®, Levemir®, Tresiba®, Humulin I®, Abasaglar®, Toujeo®, Semglee®)

Adjusting insulin for people with type 2 diabetes mellitus on basal insulin only

- If glucose is higher on waking than at bedtime, increase dose by a maximum of 10% every 3 days until waking glucose is similar to bedtime. With Tresiba® and Toujeo increase the dose a maximum of every 3-5 days. The dose would generally be increased in 2, 4 or 6 unit increments dependent on the existing doses and improvement in glucose required. For example, for a 2-3 mmol/l improvement increase dose by 5% initially and for greater than a 5 mmol/l improvement increase dose by 10%. If nocturnal or waking hypoglycaemia review glucose levels during the day. If low in the day reduce insulin dose by 20%. If elevated, consider a change from an intermediate acting insulin to a longer acting analogue. Also consider carbohydrate intake and other diabetes medications.

Mixed insulin regimens

(Novomix 30®, Humalog Mix 25®, Humalog Mix 50®, Humulin M3®,

- Relevant doses should be increased by 10% if hyperglycaemic or reduced by 20% in the case of hypoglycaemia. The dose would generally be increased in 2, 4 or 6 unit increments dependent on the existing doses and improvement in glucose required. For example for a 2-3 mmol/l improvement increase dose by 5% initially and for greater than a 5 mmol/l improvement increase dose by 10%. Clinical judgement and experience to be used.
- If glucose is high at lunchtime or evening meal increase the morning insulin. If glucose is high at bedtime or breakfast increase the evening insulin. If glucose is low at lunchtime or evening meal decrease the morning insulin. If glucose is low at bedtime or breakfast decrease the evening insulin
- Adjustment of any dose of mixed insulin will affect glucose levels for the next 12 hours following that dose therefore glucose levels for the whole of this period need to be considered before any adjustment is made.

More concentrated insulins

Standard insulin strength in the UK is U100 (100 units per ml). An increasing range of insulins are available in a more concentrated form. For example, Humalog® is available as U100 and U200, Tresiba® as U100 and U200. Toujeo® is a U300 insulin.

These insulins are often used when large doses are required and poor absorption is suspected. It is therefore important to be cautious when increasing doses when someone has recently changed to one of these insulins as better absorption of the insulin will increase bioavailability.

Dose Adjustment for Physical Activity

On a basal bolus regimen or CSII quick acting insulin can be reduced before or after exercise to reduce the risk of hypoglycaemia. Consider the timing, intensity and duration of the activity. Basal insulin could also be reduced by 20% if on BD Levemir (or CSII) to avoid delayed or night time hypoglycaemia. On a Hybrid Closed Loop pump choose the exercise or higher target levels.

See leaflet 'Exercise and diabetes- a guide for people with type 1 diabetes mellitus'.

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Dose Adjustment for sick day rules

Additional quick acting insulin may be required during illness especially with type 1 diabetes mellitus when ketones are present. See WHAT-END-001 'Guideline for the Treatment of Diabetic Ketoacidosis'.

Management of hypoglycaemia

See WAHT-END-004 'Guideline for the Management of Hypoglycaemia'.

Insulin dose adjustments for people using continuous subcutaneous insulin infusion (CSII):

Further training in insulin pump therapy is required before advising on dose adjustment for people on CSII.

Adjusting Basal Rates

- If hypoglycaemia is occurring and it appears to be due to the basal rates (e.g. occurring overnight or just before mealtimes) the basal rate should be reduced by 20% in the time block commencing 90-120 minutes before the problem arises.
- With hyperglycaemia RDs would not normally increase basal rates. DSNs would increase basal rates by 10% from 90-120 minutes before the period of raised glucose.

Adjusting Carbohydrate ratios

The following test should be done to verify if the insulin: carbohydrate ratio is correct.

NOTE: this test should not be done on a day that the person with diabetes feels unwell, stressed or more exercise than usual is planned.

1. Test BG pre-meal (the test is more effective if glucose is in range pre meal).
2. Ensure the carbohydrate in the meal is correctly counted. 30-40g carbs should be taken so that a normal bolus can be used during this test.
3. Use the usual insulin to carbohydrate ratio to calculate insulin bolus.
4. Do not have a snack or drink containing carbs for the next 4 hours
5. Check glucose at 4 hours post meal.
6. If the glucose is out of target, review the insulin to carbohydrate ratio.
7. The carbs per 1 unit of insulin is increased or decreased by 1 or 2 grams, depending on change in glucose pre- to 4 hour post meal.
8. If at any stage during the test the BG drops below 4 mmol/l, stop the test and treat the hypoglycaemic episode.

Check glucose over the next 48 hours to confirm the adjustment has worked

How to assess carb ratios when using a hybrid closed loop system

The steps to assessing carb ratios are:

1. Check the accuracy of your carb counting
2. Ensure boluses are being taken 15 mins before meals (5 minutes on ultra rapid insulin).
3. Review the data for patterns:
4. If a carb ratio is too strong, the bolus will be too large, and glucose will fall below target after the meal. The system will suspend soon after the meal to try to avoid hypoglycaemia. This may then cause Glucose to rise again later.
5. If a carb ratio is not strong enough, the bolus will be too small, and Glucose will rise above target after the meal. The system will add extra insulin after the meal to try to bring the Glucose down. This will lead to less time in range.
6. Adjust ratio by 1 to 2 g carbs at a time
7. Look back over the next 48 hours and see how this has worked.

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PART 3 - Educating People To Self-Manage Their Diabetes

RD's and DSNs have a key role in educating and supporting people with diabetes to self-manage their diabetes and make adjustments to their insulin doses in groups and 1:1 settings.

Diabetes Structured Education programmes are evidence-based programmes where the educators have undergone specific training and on-going assessment. People with diabetes may be encouraged to adjust their insulin doses and changes may be made to their insulin regimens.

DAFNE

This is an evidence-based approach for people with type 1 diabetes mellitus on a basal bolus insulin regimen or CSII, designed to promote autonomy and self-care of diabetes, the principles of which are to adjust insulin doses dependent on the chosen carbohydrate intake. People with diabetes attend a 6 week course and receive on-going support from DAFNE educators.

DAFNE educators (Diabetes Specialist Dietitians and DSNs) receive competency based training and on-going assessment in the form of both internal and external peer review.

VICTOR

This is an evidence-based approach for people with type 2 diabetes mellitus on a basal bolus/basal plus insulin regimen, designed to promote autonomy and self-care of diabetes, the principles of which are to adjust insulin doses dependent on the chosen carbohydrate intake using ratios or fixed doses. People with diabetes attend a 5 week.

VICTOR educators (Diabetes Specialist Dietitians and DSNs) receive competency based training and on-going assessment in the form of both internal and external peer review.

X-PERT INSULIN

As with DAFNE this is a nationally accredited diabetes structured education programme with recognised training and quality assurance of educators.

Over the duration of the 6 week course people with diabetes may be advised to and/or learn how to adjust their insulin doses. These changes would normally be in line with the guidance in this document.

NICE guidance states that people should have the opportunity to attend Diabetes Structured Education. The RD or DSN should refer appropriately to these programmes.

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Monitoring

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: (Responsible for also ensuring actions are developed to address any areas of non- compliance)	Frequency of reporting:
	WHAT?	HOW?	WHEN?	WHO?	WHERE?	WHEN?
Whole document	Insulin adjustments are made in line with the guidance	Review of any diabetes related incident where insulin has been adjusted inappropriately.	Annual review of diabetes incidents	Lead Nurse for Diabetes	Diabetes Directorate Meeting. Division of Medicine and or Women's and Children's governance meetings and MSC	Annually or sooner if an incident causing harm is identified.

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References

Remote DAFNE educator manual for people with type 1 diabetes using multiple daily injection therapy. (version 7 July 2023).

VICTOR (Remote) educator manual for people living with type 2 diabetes using multiple dose injection (MDI) therapy (version 3 July 2025)

Remote Pump DAFNE educator manual for people with type 1 diabetes using insulin pump therapy (CSII) . (version 5 August 2023).

Hybrid Closed Loop Supplement. Remote pump DAFNE participant course (July 2022)

An integrated career and competency framework for Diabetes Nursing produced by the Diabetes UK professional education working group and TREND . 4th Edition 2015.

An integrated career and competency framework for Dietitians and frontline staff produced by the Diabetes UK professional education working group in 2011. Updated 2013

NICE guideline (NG28) Type 2 diabetes in adults: management. Dec 2015. Updated June 2022

NICE guideline (NG17) Type 1 diabetes in adults: diagnosis and management. August 2015. Updated August 2022

[You should include external source documents and other Trust documents that are related to this Policy. All references should be 'Harvard' referenced, e.g.:

Contribution List

This key document has been circulated to the following individuals for consultation:

Designation
Diabetes Dietitians
Diabetes Specialist Nurses
Diabetes and Endocrine Consultants
Specialist Pharmacist for Diabetes
Diabetes Specialist Midwives

This key document has been circulated to the chair(s) of the following committee's / groups for comments:

Committee
Diabetes Directorate Meeting

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Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.



Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form

Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	✓	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	
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Details of individuals completing this assessment	Name	Job title	e-mail contact
	Alison Hall	Lead Nurse for Diabetes	Alison.hall24@nhs.net
Date assessment completed	12/02/2026		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	Title: GUIDELINE FOR MEMBERS OF THE MULTI DISCIPLINAR DIABETES TEAM WHO ARE NOT PRESCRIBERS FOR ADVISING ON INSULIN DOSE ADJUSTMENT AND TEACHING THE SKILLS OF INSULIN DOSE ADJUSTMENT TO ADULTS WITH TYPE 1 OR TYPE 2 DIABETES MELLITUS AND GESTATIONAL DIABETES
What is the aim, purpose and/or intended outcomes of this Activity?	To safely give advice to patients or other healthcare professionals on insulin dose adjustment. To teach patients safe dose adjustment,

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Who will be affected by the development & implementation of this activity?	☒ Service User ☒ Patient ☒ Carers ☐ Visitors	☒ Staff ☐ Communities ☐ Other _____
Is this:	☒ Review of an existing activity ☐ New activity ☐ Planning to withdraw or reduce a service, activity or presence?	
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	Diabetes education courses commissioned by the ICB DAFNE XPERT INSULIN	
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Advising patients on self-adjustment of insulin provides autonomy and is recommended by all NHS bodies and Diabetes charities.	
Summary of relevant findings		

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale.** Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential <u>positive</u> impact	Potential <u>neutral</u> impact	Potential <u>negative</u> impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		x		
Disability		x		
Gender Reassignment		x		
Marriage & Civil Partnerships		x		
Pregnancy & Maternity		x		

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It is the responsibility of every individual to ensure this is the latest version as published on the Trust Intranet

Equality Group	Potential <u>positive</u> impact	Potential <u>neutral</u> impact	Potential <u>negative</u> impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Race including Traveling Communities		x		
Religion & Belief		x		
Sex		x		
Sexual Orientation		x		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		x		
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		x		

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe

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How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	<i>Atwell</i>
Date signed	12/02/2026
Comments:	
Signature of person the Leader Person for this activity	<i>Atwell</i>
Date signed	12/02/2026
Comments:	



GUIDELINE FOR MEMBERS OF THE MULTI DISCIPLINAR DIABETES TEAM WHO ARE NOT PRESCRIBERS FOR ADVISING ON INSULIN DOSE ADJUSTMENT AND TEACHING THE SKILLS OF INSULIN DOSE ADJUSTMENT TO ADULTS WITH TYPE 1 OR TYPE 2 DIABETES MELLITUS AND GESTATIONAL DIABETES

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	no
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.