**Patient referred with suspected Diabetes Mellitus (DM)**

Diagnostic aid for people suspected to have Diabetes Mellitus (DM)

**Diagnostic criteria**

* **Fasting blood glucose≥7 mmol/l, once with symptoms and twice without**
* **Random blood glucose of ≥11.1 mmol/l**
* **HbA1C≥ 6.5%**

**Confirm diagnosis**

**History of unintentional weight loss?**

**No**

* **Gradual onset**
* **Overweight**
* **Family History of type 2 DM**

**Yes**

**Treat as type 1 DM**

* **Patient unwell**
* **Bicarbonate ≤ 15**
* **pH ≤7.3**
* **And blood Ketones ≥3** **mmol/l**

**Treat as type 2 DM**

**GP follow-up**

**No**

**Yes**

**Admit and treat as per Diabetic Ketoacidosis (DKA) guidelines on intranet**

**Start SC insulin and consider discharge-to be seen by OP DSNs the next working day (ext 3089)**

**Collect a “TAKE AWAY PACK” from MAU/Wd2 staff room**

**This diagnostic aid is not to replace clinical judgement but to assist the decision making process.**

 **Using the diagnostic aid for suspected Diabetes Mellitus**

* Involve the Diabetes Advanced Nurse Practitioners (DM ANP) early-

 Preferably before the patient is admitted

* Inform Diabetes ANPs of all newly diagnosed patients with diabetes (Bleep 1661 or ext 5306)
* Seek advice from DM SpR/consultants early if Diabetic Ketoacidosis (DKA) is suspected

 **Treatment of newly diagnosed type 1 Diabetes Mellitus**

* The immediate priority is to stop ketone production and avoid DKA
* Patients who are clinically well, and are not in DKA do not need to be admitted
* When discharging patients, you **MUST** leave a message on **ext 3089** (the outpatient team) with patient details, requesting early review post discharge.
* Patients must be empowered to look after their own treatment from the outset
* The best insulin regime for the patient needs to be tailored based on their abilities and preferences
* When the diabetes team are **NOT** available, twice daily (bd) subcutaneous (SC) Human Insulatard 6-10 international units SC bd is safe to commence
* Prescribe and administer insulin as requested by DM ANPs
* Insulin pen to be sent to pharmacy for labelling
* TTO’s to be completed
* DM ANP to commence education, and supply's patient literature etc
* Refer to Dietitian (can be arranged as an outpatient)
* Arrange follow up with diabetes consultant as outpatient in 6-8 weeks

 **Treatment of newly diagnosed type 2 diabetes mellitus**

* Most patients with newly diagnosed type 2 DM do not need to be admitted to

 hospital.

* Patients must be empowered to look after their own treatment from the outset
* Most people with type 2 DM are cared for by the general practitioners, unless there are significant comorbidities and complications
* Refer to Dietitian ext 3126 (can be arranged as an outpatient)
* If eGFR>35 mls/min, and creatinine <150 umol/L, metformin is the first drug of choice.
* Start metformin slowly (500 mg od week one, bd week 2 and tds from week 3 as per BNF guidlines) to minimise GI side effects
* Gliclazide may be added to improve glycaemic control more rapidly
* DM ANP to commence education, and supply patient literature etc

 **Before discharge, confirm**

* Patients or carers can test blood glucose (and blood ketones if applicable)
* Patients or carers can inject insulin
* Patients can recognise hypoglycaemia, and take necessary action
* Patients are given a “Take away pack” from MAU/wd2 staff room which includes leaflets, meter and hypo box.