

End of Life Diabetes Management

Discuss changing the approach to diabetes management with the patient and/or family if not already explored. Ensure the Diabetes Specialist Nurse (DSN) team are involved if advice on insulin and monitoring are required.

Type 2 Diabetes: Diet controlled or Metformin treated—STOP Metformin/monitoring blood glucose

TYPE 2 DIABETES

On other tablets/Insulin/GLP-1 RAs

Stop tablets and GLP-1

Consider stopping insulin if patient only requiring small dose and CBGs <10mmol/L. Monitor CBG (capillary blood glucose) once daily (OD) for 2 days. If final hours/days of life STOP CBG monitoring

If insulin stopped:

- -If CBG remain acceptable e.g. 6 -15mmol/L most of the time, no insulin or monitoring required.
- -If CBG >20mmol/L or >15mmol/L and symptoms of hyperglycaemia consider OD Glargine (e.g. Lantus/ Semglee). Refer to 'Insulin to continue' box.
- Observe for symptoms in previously insulin treated individuals where insulin has been discontinued.

If insulin to continue:

- Prescribe OD Glargine (e.g. Lantus/Semglee) in the morning based on 25% less than previous total daily insulin dose
- Titrate by 10-20% 36-72 hourly aiming to achieve CBGs 6-15mmol/L (allow <20mmol if no signs of hyperglycaemia)
- -Monitor CBG OD at time supper time.

TYPE 1 DIABETES

Patient will still need some insulin until end of life

Continue basal insulin Once Daily (OD) in the morning with reduction in dose (if on BD mixed insulin switch to OD Glargine (e.g. Lantus/Semglee)

If patient managing to eat small amounts/~50% of meal:

- Give rapid-acting insulin (e.g. NovoRapid) <u>post-meal</u> titrated to amount eaten to achieve acceptable CBGs and avoid DKA developing

If patient not eating/<50% meal:

- OMIT and/or STOP rapid-acting insulin (e.g.NovoRapid/ Humalog) to avoid hypoglycaemia but continue OD basal insulin as above

Check CBG once daily at supper time:

- If CBG <8mmol/L reduce insulin dose by 10-20%
- If CBG >20mmol/L increase insulin dose by 10-20% to reduce risk of symptoms or ketosis.

DISCONTINUE INSULIN AND CBG MONITORING WHEN CLINICAL TEAM AND CARERS/FAMILY AGREE CONSEQUENCES OF UNCONTROLLED HYPERGLYCAEMIA ARE LESS BURDONSOME FOR PATIENT THAN PROCESS OF MONITORING AND INJECTIONS.

IMPORTANT INFORMATION:

- Aim for CBGs 6-15mmol/L. Use clinical judgement to determine if higher glucose acceptable if no symptoms present. N.B. It is difficult to identify symptoms due to "hypo" or hyperglycaemia in a dying person. Observe for symptoms in previously insulin treated individuals where insulin has been discontinued.
- Keep CBG monitoring tests to a minimum. It may be necessary to perform some tests to ensure unpleasant symptoms do not occur due to low or high blood glucose.
- Flash glucose monitoring may be useful in these individuals to avoid finger pricking.
- Contact the Diabetes Department if further advice required via an E-Referral or call EXT 6517 for urgent advice

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