

Communication Checklist: Signs and Symptoms of Hyper or Hypoglycemia with Diabetes

This tool can be:

- Used to provide a SBAR framework for change in communication when signs or symptoms of hyperglycemia or hypoglycemia are identified.
- Modified to include facility specific protocols for hyperglycemia or hypoglycemia.
- Used as part of your staff orientation and training on change in condition communication.

SBAR Prompts	Admission Date: _____ Resident Name: _____	
Variation in patient blood sugar levels	<input type="checkbox"/> Hypoglycemia (low blood sugar) <i>check all observed:</i> <input type="checkbox"/> shakiness <input type="checkbox"/> dizziness <input type="checkbox"/> sweating <input type="checkbox"/> inability to concentrate <input type="checkbox"/> fast heartbeat <input type="checkbox"/> confusion <input type="checkbox"/> irritability or moodiness <input type="checkbox"/> headache <input type="checkbox"/> hunger <input type="checkbox"/> anxiety or nervousness <input type="checkbox"/> asymptomatic Time period symptoms observed (e.g., 1 reading, 3 breakfasts with abnormal levels): _____	<input type="checkbox"/> Hyperglycemia (high blood sugar) <i>check all observed:</i> <input type="checkbox"/> fruity smelling breath <input type="checkbox"/> coma <input type="checkbox"/> nausea and vomiting <input type="checkbox"/> weakness <input type="checkbox"/> shortness of breath <input type="checkbox"/> dry mouth <input type="checkbox"/> abdominal pain <input type="checkbox"/> confusion <input type="checkbox"/> asymptomatic Time period symptoms observed (e.g., 1 reading, 3 breakfasts with abnormal levels): _____
Current blood sugar reading	Value: _____ Time of reading: _____	
PRN Medications Utilized	Medication: _____ Dose: _____ Date: _____ Time: _____ Post Medication Blood Sugar: _____	Medication: _____ Dose: _____ Date: _____ Time: _____ Post Medication Blood Sugar: _____
Most Recent HGA1C and date	Date: _____ HBA1C Value: _____	
Vital Signs	Temperature: _____ Route: _____ Baseline Temperature: _____ B/P: _____ Heart Rate: _____ Respiratory Rate: _____	
Current mentation	<input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Difficult to arouse <input type="checkbox"/> Other: _____ Is this the baseline for resident/patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Goals of Care	Briefly list goals of care (e.g., do not hospitalize)	

Current Diabetic medications	<input type="checkbox"/> Oral Agent <input type="checkbox"/> Insulin Name: _____ Dose: _____ Frequency: _____	<input type="checkbox"/> Oral Agent <input type="checkbox"/> Insulin Name: _____ Dose: _____ Frequency: _____	<input type="checkbox"/> Oral Agent <input type="checkbox"/> Insulin Name: _____ Dose: _____ Frequency: _____
Routine sliding insulin scale	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, has resident been requiring more <input type="checkbox"/> or less <input type="checkbox"/> than usual?		
Medications that impact blood sugar	<input type="checkbox"/> Antibiotics (med): _____ <input type="checkbox"/> Dilantin: _____ <input type="checkbox"/> Corticosteroid (med): _____ <input type="checkbox"/> Thyroid medications (med): _____ <input type="checkbox"/> Heart/BP meds (med): _____ <input type="checkbox"/> Antipsychotics (med): _____ <input type="checkbox"/> Quinine: _____ <input type="checkbox"/> Estrogens: _____ List any of these medications that are new:		
Recent medications changes	Date: _____ Medication: _____ Dose: _____ Date: _____ Medication: _____ Dose: _____ Date: _____ Medication: _____ Dose: _____		
Changes in eating patterns	Time period of observation: _____ (i.e. last 3 meals) Amount eaten: _____ (i.e. 25%, 50% of meals)		
Co-morbidities	<input type="checkbox"/> Heart Disease: <i>diagnosis</i> _____ <input type="checkbox"/> Kidney Disease: <i>diagnosis</i> _____ <input type="checkbox"/> Respiratory Disease: <i>diagnosis</i> _____ <input type="checkbox"/> Liver Disease: <i>diagnosis</i> _____ <input type="checkbox"/> Obesity		
Interdisciplinary Team Recommendations	<input type="checkbox"/> Pharmacist: _____ <input type="checkbox"/> Registered Dietitian: _____ <input type="checkbox"/> Other: _____		

Notes: