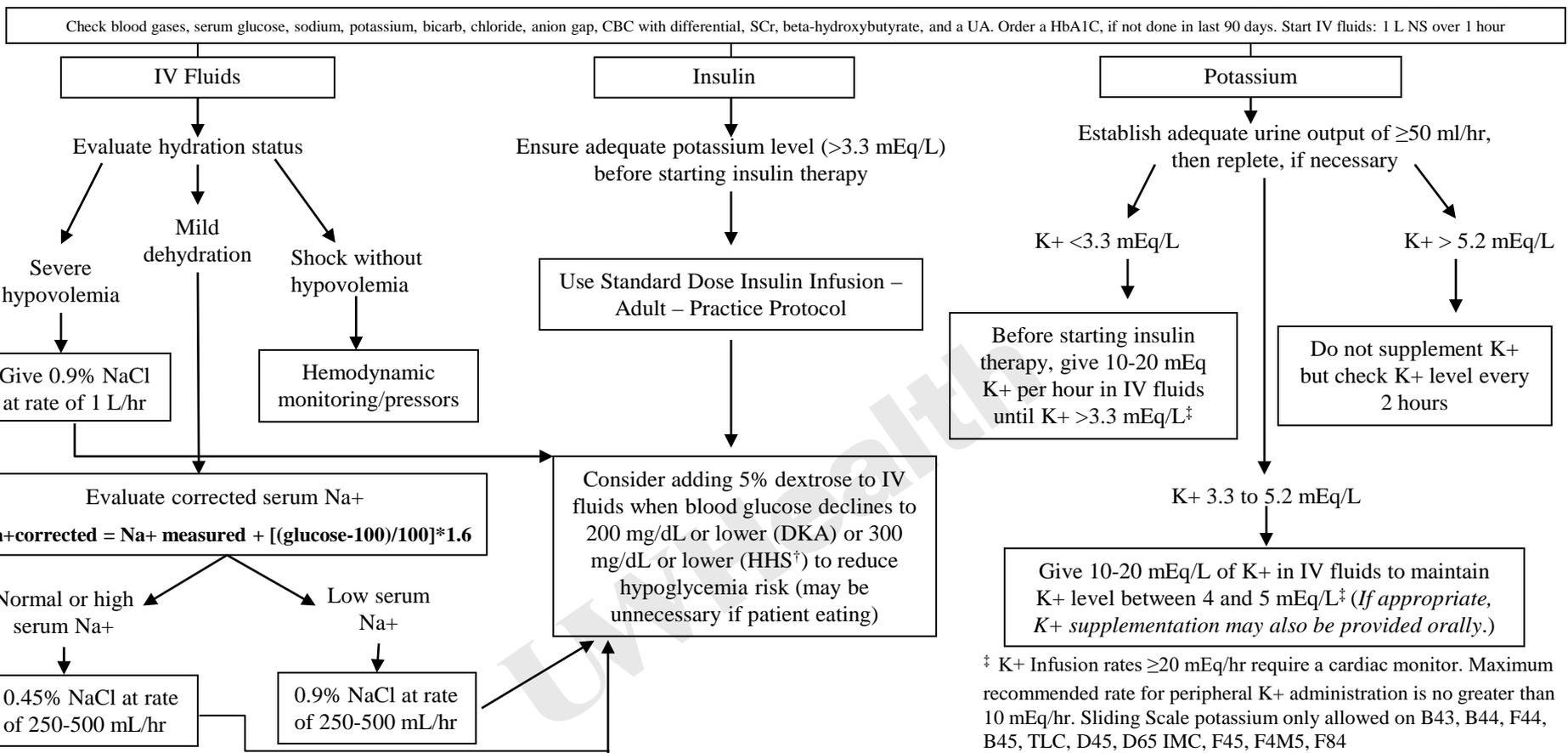


Diabetic Ketoacidosis (DKA) Management Algorithm (Adult Patients)



† For a patient in HHS, keep blood glucose between 200 - 300 mg/dL until patient is mentally alert.

Hourly glucose monitoring required every hour until glucose within target range of 110-150 mg/dL for 3 hours, then check every 2 hours. Resume hourly monitoring if blood glucose deviates from the target range. Check electrolytes and phosphate level every 2 hours times two, then every 4 hours. Check a beta-hydroxybutyrate level every 8 hours. Bicarbonate supplementation is only recommended in patients with life-threatening acidosis (pH of < 6.9) ; bicarbonate therapy may increase risk of hypokalemia and cerebral edema. Identify and treat the cause of the DKA precipitation.

DKA Resolution/IV to SQ Transition: Insulin infusion should be continued until acidosis has resolved, as demonstrated by pH >7.3, bicarbonate >18 mmol/L, blood glucose <200 mg/dL, and normalization of anion gap. After resolution, if patient is able to eat, transition to subcutaneous (SQ) insulin. Refer to order set ED/IP - Diabetes - Insulin Transition - IV to Subcutaneous - Adult - Supplemental [5254]. Overlap the insulin drip with the SQ insulin by 2 or more hours. For an insulin-naïve patient, calculate the daily insulin dose received via insulin infusion in the last 24 hours, decrease by 20%, and split the remainder up as ½ basal insulin and ½ mealtime insulin (mealtime dose to be divided between all meals).

Fayman, M., Pasquel, F.J., Umpierez, G.E. Management of hyperglycemic crises: Diabetic ketoacidosis and hyperglycemic hyperosmolar state. *Med Clin N Am.* 2017;101:587-606. Last updated: May 2022 | Last Reviewed April 2023
 American Diabetes Association. Standards of Medical Care in Diabetes-2023. *Diabetes Care.* 2023;46(Suppl 1): S1-292. Questions? Contact Inpatient Diabetes Quality Committee