Alberta Health Services

# PROTOCOL

**TITLE**
## DIABETES MEDICATION ADJUSTMENT - ADULT

**SCOPE**
Provincial: Adult Diabetes Specialty Out-Patient Centres

**DOCUMENT #**
HCS-296-01

**APPROVAL AUTHORITY**
Senior Provincial Director
Senior Medical Director
Diabetes, Obesity and Nutrition Strategic Clinical Network

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**NOTE:** The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

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## OBJECTIVES

- To provide direction to **health care professionals** (with diabetes management expertise) and work in a specialty diabetes out-patient centre(s) in the adjustment of antihyperglycemic medications.
- To support collaboration with and between the patient's health care team.
- To standardize the advice provided to **patients** with diabetes, who are referred to an adult specialty diabetes out-patient centre, on the adjustment of their antihyperglycemic medications, including insulin, administered in the patient's **home setting**.
    - It is the responsibility of the health care professional to extend involvement to **family** as determined by the patient (as appropriate).

## APPLICABILITY

Compliance with this document is required by all Alberta Health Services employees, members of the medical and midwifery staffs, students, volunteers, and other persons acting on behalf of Alberta Health Services (including contracted service providers as necessary).

## ELEMENTS

### 1. Points of Emphasis

1.1 Each Zone shall designate the adult specialty diabetes out-patient centre(s) that employs health care professionals with diabetes management expertise.

1.2 Adjustment of antihyperglycemic medications requires a collaborative approach from the health care team. It is important to engage the patient, family and all involved **health care providers** and to support them in the goal of achieving individualized glycemic targets as well as providing education related to self-management skills around medication adjustments.

1.3 A patient specific **order** from **the most responsible health practitioner (MRHP)** is required to enact this Protocol.

1.4 This protocol applies to:

a) Registered Nurses and Pharmacists competent to perform the interventions in this Protocol, within their scope of practice; and

b) Registered Dietitians, who are competent to perform the interventions in this Protocol, within their scope of practice and when included in their current role.

1.5 The **accountable leader** in collaboration with the health care professionals shall determine the initial and ongoing education required for competency to enact this Protocol for the adjustment of diabetes medications. This may include specific education on self-management of diabetes and diabetes medication(s) dose adjustments.

(i) For Registered Dietitians, the accountable leader refers to the **manager**.

1.6 Health care professionals shall confirm that **informed consent** (express or implied) is received from the patient and/or guardian as appropriate for ongoing treatment recommendations as per the AHS *Consent to Treatment/Procedure(s)* Policy Suite.

a) For situations involving minors, refer to the AHS *Consent to Treatment/Procedure(s): Minors/Mature Minors* Procedure.

## 2. Inclusion Criteria

2.1 This protocol applies to adult patients:

a) diagnosed with diabetes mellitus; and

b) who have been seen in a specialty out-patient diabetes care centre by the multidisciplinary care team within the past twelve (12) months.

2.2 This protocol may be applied to a **minor** when the MRHP refers the pediatric patient to the adult specialty diabetes care centre(s) and provides a patient specific order for this protocol.

## 3. Exclusion Criteria

3.1 This protocol is not intended for pediatric patients with diabetes.

a) There may be an exception for pediatric patients with diabetes who have been referred to the adult specialty diabetes care centre(s), per Section 2.2.

## 4. Acquiring Information

4.1 The health care professional should take the following information into consideration when determining dose adjustments, if the information is available:

a) type of diabetes;

b) reported self-monitored glucose values including capillary blood glucose (CBG), intermittently scanned continuous glucose monitoring (isCGM), real time continuous glucose monitoring (rtCGM) and masked continuous glucose monitoring (mCGM) value(s) from the home setting;

(i) review lab values for glucose meter accuracy, if applicable. If annual test not completed or when A1C does not match self-monitored glucose readings, the health care professional can coordinate with the patient and the authorized prescriber to ensure a glucose meter accuracy check is evaluated per *Diabetes Canada Clinical Practice Guidelines*.

c) glycemic control as reflected in the A1C;

(i) review lab values for recent A1C in the previous three to six months. If the A1C has not been evaluated as recommended, the health care professional can coordinate with the patient and the authorized prescriber to ensure an A1C is evaluated. In some circumstances, such as when significant changes are made to therapy or during pregnancy, it is appropriate to check A1C more frequently, refer to *Diabetes Canada Clinical Practice Guidelines* for more information on recommended A1C evaluation.

d) reported insulin or non-insulin antihyperglycemic agent(s) (non-insulin AHA) regimen and dose(s);

e) glycemic response (or lack of) to recent dose adjustment;

f) weight or weight changes;

g) diet/nutrition plan;

h) activity level;

i) current health status;

j) comorbidities;

k) pregnancy status;

l) medication(s) that impact glycemic management (e.g., glucocorticoids, etc.); and

m) other factors that impact glycemic management.

4.2 The health care professional shall:

a) confirm the patient's identity by using at least two (2) identifiers as per the AHS *Patient Identification* Policy, such as but not limited to:

(i) both the first and last name (considered one [1] identifier);

(ii) full date of birth (inclusive of day, month, year);

(iii) **Unique Lifetime Identifier (ULI);**

b) complete Best Possible Medication History with the patient, refer to medication reconciliation policy;

c) confirm the patient's preferred method for follow-up contact (e.g., phone number).

4.3 If requests are received for support with glucose management, diabetes medication dosage adjustment and/or prevention of hypoglycemia and hyperglycemia emergencies, the health care professional shall when clinically relevant:

a) obtain and record reported glucose (CBG, isCGM, rtCGM or mCGM) values, insulin doses, non-insulin AHA or other medications self-administered by patient, family and/or health care provider, and other relevant information in the health record;

b) complete a chart review (e.g., the current non-insulin AHA medication(s)/insulin dose orders, the frequency of administration, nutrition plan, changes in medical conditions if applicable);

c) inquire if any significant changes have occurred in personal circumstance or lifestyle behaviours which may include but are not limited to:

(i) frequency and/or timing of medication administration;

(ii) home nutrition and diet routines;

(iii) current or recent illness;

(iv) development of new comorbidities;

(v) medications (e.g., recently added or discontinued);

(vi) pregnancy;

(vii) daily schedule (e.g., shift work, physical activity, etc.); and/or

(viii) personal circumstances (e.g., job loss, relationship changes, changes in health and social benefits, etc.)

d) If patient is on an insulin regimen, calculate the current average total daily insulin dose in units per kilogram (kg) body weight per/day (using the most recently recorded or estimated weight).

4.4 The health care professional shall assess if a potential acute safety concern is present (e.g., insulin pump failure, acute illness, presence of ketones, medication error, etc.).

a) If no acute safety concern is identified, determine (in collaboration with the patient if appropriate), the pattern of hypoglycemia or hyperglycemia using pattern management principles.

## 5. Glucose Targets

5.1 Health care professionals shall refer to *Diabetes Canada Clinical Practice Guidelines* for glucose targets for patients with diabetes mellitus unless individualized targets are identified for the patient.

## 6. Insulin Adjustment

6.1 When the health care professional is informed the ketone status is negative or in the absence of known ketones, the health care professional may provide recommendations to the patient to adjust an insulin dose up to 20% or 1 unit (whichever is higher) of the current total daily dose of insulin to the patients identified glucose target.

a) Advise patient to adjust insulin every 1-2 days until glucose targets met.

(i) Exception: patient using ultra-long acting basal insulin (e.g., degludec) may adjust this insulin every 4 days or once weekly

6.2 Dose adjustments exceeding 20% of the current total daily dose require review, direction and an order from the patient's MRHP (e.g., Physician, Nurse Practitioner or designate).

a) Exception: Orders are not required if the specialty diabetes out-patient centre's resource documents so indicate (e.g., diabetes in pregnancy protocols).

6.3 Dose adjustments for prevention of hypoglycemia and/or frequent hypoglycemia (3 or more episodes in a week) may require a larger percentage decrease of the

total daily dose, by 50%, in insulin adjustment based on discussion with the patient and the health care professionals' discretion.

a) Re-evaluation of glucose values and insulin doses shall be determined in collaboration with the patient.

b) Exception: Orders are not required if the specialty diabetes out-patient centre's resource documents so indicate (e.g., diabetes in pregnancy protocols).

6.4 Health care professionals with education and training in insulin adjustments for insulin pump therapy shall consider the technology the patient is using for insulin pump therapy when providing insulin adjustment advice to the patient.

6.5 When the health care professional is informed ketone status is positive or the patient has special consideration to insulin adjustment, they shall refer to Section 8 for further guidance.

## 7. Non-Insulin Antihyperglycemic Agent (Non-Insulin AHA) Adjustment

7.1 The health care professional shall titrate medications to patient's identified glucose targets or optimized therapeutic dose as per the medication's Health Canada product monograph.

a) Exception: the medication's product monograph is not followed when there are patient specific orders or the specialty diabetes out-patient centre's resource documents indicate otherwise (e.g., Sodium-glucose cotransporter 2 inhibitors (SGLT-2i) use and prevention of diabetes ketoacidosis in Type 1 Diabetes).

## 8. Special Considerations Medication Adjustment

8.1 Illness

a) The health care professional shall advise the patient to hold (pause) and/or decrease medications during patient reported illness or dehydration, *as per Diabetes Canada Clinical Practice Guidelines.*

b) The health care professional shall encourage the patient to monitor their glucose more frequently during illness.

(i) CBG values are preferred, as isCGM and rtCGM values may be inaccurate during illness.

c) The health care professional shall encourage the patient to drink sugar free or minimal sugar containing fluids unless advised otherwise (e.g., heart failure, advanced chronic kidney disease, etc.) to prevent dehydration.

d) To prevent hypoglycemia, the health care professional shall encourage the patient eating less than normal on insulin or secretagogue medications to consider:

(i) reducing dose of insulin; and/or

(ii) reducing or holding insulin secretagogue; and

(iii) consuming carbohydrate containing foods and fluids with approximately 15 grams of carbohydrates as able to tolerate.

e) When patients report illness and/or dehydration, the health care professional shall recommend ketone testing for patients with:

(i) Type 1 diabetes mellitus and glucose greater than 14.0 mmol/L;

(ii) Insulin pump therapy and glucose greater than 14.0 mmol/L;

(iii) Individuals taking SGLT2i medications with symptoms of Diabetic Ketoacidosis.

f) For patients with Type 1 diabetes mellitus or those using insulin pump therapy;

(i) when the health care professional is informed the patient has a CBG greater than 14.0 mmol/L **and** blood ketones results of 0.6 mmol/L or more **or** urine ketones above trace (above 5 mg/dL), the patient is advised to:

- Self-administer a bolus of insulin, 1.5 times the amount of correction insulin via insulin pen or syringe, not by insulin pump.
  - Calculation for correction insulin:

$$1.5 \times \frac{(\text{current blood glucose - target blood glucose})}{(\text{insulin sensitivity factor } \textit{or} \text{ correction factor})} = \text{x units of insulin}$$

- Hydrate with 1 cup (250 mL) of sugar free fluids every hour
- Recheck glucose frequently (e.g., hourly or every 2 hours as determined in collaboration with the patient)
- Hold Sodium-glucose cotransporter 2 inhibitors (SGLT-2i) or Glucagon-like peptide-1 receptor agonists (GLP-1 RA), if taking these medications.
- In those with type 1 diabetes on SGLT-2i, the consumption of carbohydrate with additional insulin may be needed to reverse ketosis.

g) The health care professional shall advise the patient to seek care at the closest emergency department as soon as possible for assessment and evaluation of hyperglycemic emergencies (e.g., DKA, Hyperosmolar Hyperglycemic State) when the patient experiences any of the following:

(i) blood ketones 3.0 mmol/L or greater, **or** urine ketones results moderate to large (2+ or more, or 40 mg/dL or more); or

(ii) CBG above 14.0 mmol/L **with** blood ketones 0.6 mmol/L or more, urine ketones trace or greater (5mg/dL or above) **after** 2 corrections of insulin **with no** improvement.

(iii) unable to tolerate fluids after four (4) hours **and/or** signs of dehydration are present (e.g., dry mouth or skin, cracked lips, sunken eyes, drowsiness, dizziness, feeling faint, pounding heartbeat); and/or

(iv) symptoms of DKA including but not limited to nausea, vomiting, stomach pain, trouble breathing or deep/rapid breathing, fruity-smelling breath, muscle weakness.

- Including individuals treated with SGLT2i medication regardless of glucose level.

(v) an insulin pump failure **with** no plan or ability to replace insulin.

(vi) Altered mental status.

(vii) Other reported signs and symptoms of acute illness (e.g., signs and/or symptoms of a cardiovascular event, sepsis, etc.)

h) Exception: for those patients with known diabetes in pregnancy follow the specialty diabetes out-patient centre's resource documents and or contact MRHP.

8.2 Patients with Upcoming Medical procedures

a) For procedures with extended preparation (e.g., colonoscopy), advise glucose monitoring at least every four (4) hours during the preparation period.

b) For procedures with clear liquid diet preparation (e.g. the day before a colonoscopy) consider:

(i) reducing both the basal and bolus insulins by 20%; and

(ii) stopping SGLT2-i medications two days prior procedure.

c) On the night before the procedure: consider reducing basal or mix insulin by 20% the night prior to the procedure.

(i) Exception: for patients using ultra-long acting basal insulin (e.g., degludec), reduce by up to 20% 2-3 days before the procedure if there is a concern of hypoglycemia.

d) In the morning of the procedure: consider reducing basal insulin by 20% and holding bolus or mix insulin and other non-insulin AHA until after the procedure, unless indicated otherwise.

(i) Exception: for patients using ultra-long acting basal insulin (e.g., degludec), reduce by up to 20% 2-3 days before the procedure if there is a concern of hypoglycemia.

(ii) See reference section for more information.

e) For patients that use insulin pump therapy, refer to the AHS *Guidelines for the Safe Management of Insulin Pump Therapy in-hospital (*refer to the algorithm for the safe use of insulin pump during procedures and surgery*).*

(i) A temporary alternate insulin therapy regimen may be required for procedures resulting in cognitive impairment of more than 2 hours (e.g., conscious sedation of more than 2 hours or any general anesthesia). This requires a collaborative discussion with the patient and the most responsible health care professional.

8.3 Patients who Travel

a) The health care professional must calculate time change difference, if applicable, using the patient's itinerary to determine what antihyperglycemic medication adjustments (if any) are required to keep the patient safe.

(i) The health care professional must notify the patient's MRHP if medication changes are required (e.g., dose alterations and/or timing of taking the medication).

b) Traveling to a time zone less than two (2) hours difference does not usually require any adjustment to insulin or secretagogue.

c) Medications other than insulin or secretagogue do not usually require any adjustments other than the time they are taken, until the person is at their destination.

d) Encourage increased frequency of glucose monitoring for those on insulin or secretagogue medications during travel.

8.4 Patients who work Shiftwork

a) Consider long acting analogue basal insulin with less of a peak for insulin action;

b) Consider shorter acting secretagogue;

c) Shiftwork may require different basal profiles in insulin pump or different basal/bolus dosing in multiple daily injection regimens.

d) Encourage increased frequency of glucose monitoring for those on insulin or insulin secretagogue medication during shift changes.

8.5 Renal Considerations

a) Patients with eGFR less than 60 mL/min/1.73 $m^2$ are at increased risk of hypoglycemia as renal function declines. Renal dysfunction prolongs medication excretion; therefore medication dose adjustments or discontinuation may be considered.

(i) Refer to *Diabetes Canada Clinical Practice Guidelines (chapter 13)* for information on insulin and non-insulin AHA medications and renal function, based on product monograph precautions.

b) Patients with chronic kidney disease are at an increased risk of acute kidney injury in the presence of dehydration and/or non-steroidal anti-inflammatory drugs (NSAIDs) when taking certain non-insulin AHA medications (e.g., SGLT2i medication). Refer to section 8.1 for guidance and direction for medication adjustments related to dehydration.

8.6 Nutrition

a) For patients on agents that cause hypoglycemia (insulin or non-insulin secretagogue AHA):

(i) advise a dose and/or timing adjustment of these medications to prevent hypoglycemia or hyperglycemia based on the patient's carbohydrate intake and schedule;

(ii) discuss with the MRHP if pharmacological options exist with less risk for hypoglycemia; and

(iii) educate the patient about appropriate treatment of hypoglycemia and its importance in preventing acute (e.g., severe hypoglycemia) and chronic conditions (e.g., development of hypoglycemia unawareness).

8.7 Physical Activity

a) Planned activity may require:

(i) the reduction of the active insulin/secretagogue in advance of the activity by 2 hours or longer in the case of basal insulin; and/or

(ii) additional carbohydrate depending on the duration and intensity.

b) Unplanned activity may require the addition of carbohydrate to prevent hypoglycemia.

c) Activity may require the reduction of insulin or secretagogue medication to avoid delayed hypoglycemia.

d) Exercise should be discouraged in patients with type 1 diabetes in the presence of glucose readings 14.0 mmol/L or greater **and** the presence of ketones (above trace or 0.6 mmol/L).

e) Encourage increased frequency of glucose monitoring during and after exercise for patients taking insulin or secretagogue medications to prevent hypoglycemia.

8.8 Corticosteroid Medications

a) These medications may cause hyperglycemia in variable patterns throughout the day depending on the glucocorticoid medication (e.g., prednisone, dexamethasone, betamethasone, intra articular steroid injection, etc.).

b) The health care professional shall encourage the patient to monitor their glucose more frequently.

c) Patients not on insulin may require an insulin start and shall be referred to their MRHP when self-monitored glucose values are above identified targets as per *Diabetes Canada Clinical Practice Guidelines*.

(i) The insulin regimen should be selected based on the specific glucocorticoid and its anticipated hyperglycemic pattern.

d) Insulin adjustments may be required to prevent or treat hyperglycemia refer to section 6.2.

e) When glucocorticoid medication doses are being lowered or discontinued the insulin dose(s) may require adjustments to prevent hypoglycemia, refer to section 6.3.

## 9. Medication Related Clinical Adverse Events

9.1 Insulin: If the patient and/or health care professional determine an insulin dosage error has occurred, provide support and advice to ensure that the patient is aware when to go to closest urgent care/emergency room and/or how to treat at home (if able). Refer to Calgary Zone Resource Document –*Insulin Dosing Errors- Too Much Insulin*.

9.2 Non-Insulin AHA: If the patient and/or health care professional determine a significant oral or non-insulin injectable medication error has occurred to the extent that toxicity is suspected, provide support and advice to call Poison and Drug Information Service (PADIS) and/or seek urgent care. If toxicity is not

suspected, however patient assessed to be at high risk of hypoglycemia, the health care professional shall provide support and advice to ensure patient is aware of when to go to urgent care and/or manage at home with increased glucose testing and carbohydrate consumption.

9.3 Refer to the AHS *Immediate and Ongoing Management of Clinical Adverse Events* Procedure, if required.

## 10. Education and Follow Up

10.1 Diabetes medication adjustments and follow up care require a collaborative effort and a multidisciplinary approach, which may involve an array of strategies and include the patient, family, and/or health care provider(s) in:

a) contacting the MHRP with recommendations regarding medication adjustments and medication changes, and with changes in the patient's status that may affect diabetes medication management;

b) providing education that supports the patient autonomy in self-management of dose adjustment(s) to medications; and

c) determining what appropriate follow up care may be required, including communication with the MHRP if the patient requires other interventions (e.g., screening for complications, referrals, etc.).

10.2 To ensure the success with self-management of diabetes, the patient may require additional support and education from the health care professional and multidisciplinary care team, including but not limited to:

a) glucose monitoring (CBG, isCGM, and rtCGM) routines (e.g., hand hygiene, testing before eating and exercise, routine review of trends in glycemic control, etc.);

b) diet and nutrition routines (e.g., carbohydrate counting, meal-time routines, alcohol, etc.);

c) subcutaneous insulin injection technique, site rotation, action and duration of insulin, and storage of insulin;

d) hypoglycemia management (e.g., treatment and management, severe hypoglycemia, driving, etc.);

e) sick day management;

f) physical activity management; and

g) social and psychological supports.

## 11. Documentation

11.1 The health care professional shall document in the patient's health record:

a) acquired information (refer to Section 4) from the patient/family;

b) recommended non-insulin AHA and/or insulin dose adjustments with rationale;

c) communication with MRHP and health care team;

d) all education/interventions provided; and

e) follow-up care recommendations.

## DEFINITIONS

**Accountable leader** means the individual who has ultimate accountability to ensure consideration and completion of the listed steps in the management of the *Adult Diabetes Medication Adjustment* Protocol. Responsibility for some or all of the components of management may be delegated to the appropriate level responsible administrative leader, but accountability remains at the senior level.

**Alternate decision-maker** means a person who is authorized to make decisions with or on behalf of the patient. These may include, specific decision-maker, a minor's **legal representative**, a **guardian**, a 'nearest relative' in accordance with the *Mental Health Act* (Alberta) or an agent in accordance with a personal directive or a person designated in accordance with the *Human Tissue and Organ Donation Act* (Alberta). This also includes what was previously known as the substitute decision-maker.

**Authorized prescriber** means a health care professional who is permitted by federal and provincial legislation, their regulatory college, Alberta Health Services, and practice setting (where applicable) to prescribe medications.

**Family(-ies)** means one or more individuals identified by the patient as an important support, and who the patient wishes to be included in any encounters with the health care system, including but not limited to, family members, legal guardians, friends, and informal caregivers.

**Guardian** means, where applicable:
For a minor:

a) A guardian as defined by the *Family Law Act* (Alberta), a divorced parent with custody of the minor, or a person appointed pursuant to a will, personal directive, court order, agreement or by authorization of legislation (e.g., *Child, Youth and Family Enhancement Act* [Alberta]).

For an adult:

a) An individual appointed by the Court in accordance with the *Adult Guardianship and Trusteeship Act* (Alberta) to make decisions on behalf of the adult patient when the adult patient lacks capacity.

**Health care professional** means an individual who is a member of a regulated health discipline, as defined by the Health Disciplines Act (Alberta) or the Health Professions Act (Alberta), and who practices within scope and role.

**Health care provider** means any person who provides goods or services to a patient, inclusive of health care professionals, staff, students, volunteers and other persons acting on behalf of or in conjunction with Alberta Health Services.

**Health record** means the collection of all records documenting individually identifying health information in relation to a single person.

**Home setting** means places where patients live and receive care but are not Health Care Facilities (and includes but is not limited to patients' Private Homes, Supportive Living Level 1 [SL1], and Supportive Living Level 2 [SL2] sites).

**Informed consent** means the patient's agreement (or **alternate decision-maker**) to undergo a treatment/procedure after being provided, in a manner the patient can understand, with the relevant information about the nature of the treatment/procedure(s), its benefits, potential risks and alternatives, and the potential consequences of refusal.

**Legal representative** means the following in relation to a minor, as applicable:

a) guardian; or
b) nearest relative as defined in the *Mental Health Act* (Alberta), who has the authority to consent to treatment for a minor formal patient or minor who is subject to a Community Treatment Order.

**Manager** means the individual(s) who has the delegated human resource authority for directly planning, monitoring, and supervising direct (employee) reports.

**Minor** means a patient aged less than 18 years.

**Most responsible health practitioner** means the health practitioner who has responsibility and accountability for the specific treatment/procedure(s) provided to a patient and who is authorized by AHS to perform the duties required to fulfill the delivery of such a treatment/procedure(s) within the scope of their practice.

**Order** means a direction given by a regulated health care professional to carry out specific activity(-ies) as part of the diagnostic and/or therapeutic care and treatment to the benefit of a patient. An order may be written (including handwritten and/or electronic), verbal, by telephone, or facsimile.

**Patient** means all persons, inclusive of residents and clients, who receive or have requested health care or services from Alberta Health Services and its health care providers. Patient also means, where applicable:

a) a co-decision-maker with the person; or

b) an alternate decision-maker on behalf of the person.

**Personal health number** means the patient's health care insurance number assigned to the patient by the province/territorial/federal government. (Health Information Act [Alberta])

**Unique lifetime identifier (ULI)** means a unique and permanent number assigned to all persons who receive health services in Alberta. ULIs are assigned to all Alberta residents, residents of other provinces/territories or other countries.

## REFERENCES


- Alberta Health Services Governance Documents:
  - Consent To Treatment/Procedures Policy Suite (#PRR-01)
  - Patient Identification Policy (#PS-06)
  - Immediate and Ongoing Management of Clinical Adverse Events Procedure (#PS-95-02)
- Alberta Health Services Resources:
  - *FAQ: Diabetes Medication Adjustment Protocol - Adult*
  - *Guidelines for the Safe Management of Insulin Pump Therapy in Hospital*
  - *Nutrition Guideline: Adult Diabetes* available on Nutrition & Disease Management webpage
  - *Nutrition Guideline: Household Food Insecurity* available on Food Insecurity webpage
  - *Provincial Practice Guideline for Use of Interpretation Services*
  - Resources: Diabetes, Obesity & Nutrition Strategic Clinical Network
- Non-Alberta Health Services Documents:
  - *Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada*. Diabetes Canada 2018; Can J Diabetes. 2018;42(Suppl 1):S1-S325.
  - *Insulin Dose Adjustment Position Statement,* Alberta College of Dietitians (Nov 2020)
  - *Guidelines for Prescribing and Recommending in Dietetic Practice,* Alberta College of Dietitians (Nov 2020)
  - *Blood Glucose Levels Following Intra-Articular Steroid Injections in Patients with Diabetes*, Choudhry, M.N.; Malik, R.A.; Charalambous, C.P; Journal of Bone and Joint Surgery Reviews: March 22, 2016 - Volume 4 - Issue 3 - e5