

SESLHD POLICY COVER SHEET



Health
South Eastern Sydney
Local Health District

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FORMER REFERENCE(S) <i>Documents that are replaced by this one</i>	<ol style="list-style-type: none"> Royal Hospital for Women (RHW) Clinical Policies, Procedures and Guidelines. Diabetes in Pregnancy Service (18/07/2013) St George and Sutherland Hospitals and Health Services (SGSHHS) Clinical Business Rule: Diabetes in Pregnancy, Labour, Birth and Postnatally (Feb 2012)
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KEY TERMS	Diabetes in Pregnancy; Gestational Diabetes; Pregnancy Induced Diabetes; Pre-gestational diabetes
SUMMARY	A policy to guide the screening, management and follow-up of women with Gestational Diabetes Mellitus (GDM).

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY
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1. POLICY STATEMENT

- This policy is to provide information on a District wide approach to managing **Gestational Diabetes Mellitus (GDM)**.
- This policy contains principles that are mandatory for all relevant SESLHD employees.
- This policy will replace all other hospital or sector based policies currently in place.
- For women with pre-existing Type 1 or Type 2 Diabetes please see the relevant policy (SESLHD Pre-Gestational Diabetes, Management in Pregnancy Policy – currently being drafted).

2. AIMS

- To provide consistent appropriate services to women and babies at risk of the maternal and fetal/neonatal complications of GESTATIONAL diabetes in pregnancy.
- To provide a structured pathway for education which includes diet, exercise, medication, self-care and Blood Glucose Level (BGL) monitoring to women with GESTATIONAL diabetes in pregnancy.
- To optimise glycaemic control for all women with GESTATIONAL diabetes in pregnancy.
- To detect and treat appropriately any maternal or fetal complication of GESTATIONAL diabetes manifesting during the course of pregnancy.
- To prevent or shorten hospitalisation by providing stabilisation through appropriate services.
- To liaise with Obstetricians, Endocrinologists, Midwives, Diabetes Educators, Neonatologists, Allied Health and General Practitioners to help them provide an appropriate level of care to women with GESTATIONAL diabetes in pregnancy.
- To identify women with persistent diabetes or carbohydrate intolerance following pregnancy and to ensure appropriate follow up.
- To ensure high risk groups from CALD backgrounds have equal access to services within SESLHD.

3. PATIENT GROUP/S

- Pregnant woman with known pre-existing impaired glucose tolerance (IGT)
- Pregnant woman with gestational diabetes mellitus (GDM) diagnosed in pregnancy

4. TARGET AUDIENCE

All health care providers involved in the treatment and management of GDM during pregnancy, post-partum and neonatal period including but not limited to:

- Obstetricians
- Endocrinologists
- Neonatologists
- GPs
- Midwives and Nurses
- Diabetes Educators
- Dietitians
- Physicians with an interest in diabetes

5. RESPONSIBILITIES

That the multidisciplinary team of health care providers involved in managing women with Gestational Diabetes within SESLHD adhere to this policy.

6. DEFINITIONS

ADIPS	Australian Diabetes in Pregnancy Society
ANC	Antenatal Clinic
BGL	Blood Glucose Level
CS	Caesarean Section
DE	Diabetes Educator
ECS	Elective Caesarean Section
GCT	Glucose Challenge Test
GDM	Gestational Diabetes Mellitus
GPSC	General Practice Shared Care
IDDM	Insulin Dependent Diabetes Mellitus
IGT	Impaired Glucose Tolerance
LSCS	Lower Segment Caesarean Section
MDT	Multidisciplinary team
NIDDM	Non-Insulin Dependent Diabetes Mellitus
OGTT	Oral Glucose Tolerance Test
T1DM	Type 1 Diabetes Mellitus
T2DM	Type 2 Diabetes Mellitus

7. POLICY

7.1 PRE-CONCEPTION

It is recommended that all women deemed at high risk for GDM seek pre-conceptual advice from a health professional to cover:

- Testing prior to pregnancy to diagnose any pre-gestational diabetes (pre-GDM) or Impaired Glucose Tolerance (IGT).
- Modification of any lifestyle factors such as obesity (if applicable)
- Advice regarding preconception supplements, including folate and iodine

7.2 SCREENING

Pre-Gestational Diabetes

- Women with pre-gestational Type 1 or Type 2 diabetes do NOT need screening as they are managed as having Diabetes in Pregnancy (please refer to Pre-Gestational Diabetes Policy).

Impaired Glucose Tolerance (IGT)

- Women with an Oral Glucose Tolerance Test result (OGTT) PRIOR to pregnancy which fulfils criteria for IGT* do not need further screening and should be treated as GDM and referred appropriately.
- Women with suspected but unproven IGT who haven't had an OGTT PRIOR to pregnancy require one as early as possible once pregnancy confirmed
*i.e. OGTT results that would meet current criteria for GDM in pregnancy

Oral Hypoglycaemic (e.g. Metformin) Use:

- If a woman is taking an oral hypoglycaemic agent (e.g. Metformin) prior to pregnancy for pre-gestational DM or proven IGT, then she does NOT need screening and is referred appropriately, continuing on her oral hypoglycaemic until reviewed by the Diabetes Team (DE, Dietitian, Endocrinologist/Physician)
- If a woman is taking an oral hypoglycaemic (e.g. Metformin) prior to pregnancy for OTHER reasons (e.g. ovulation induction, insulin resistance, Polycystic ovarian syndrome (PCOS)) then the oral hypoglycaemic should be ceased once pregnancy confirmed and the woman screened as per the HIGH RISK FACTORS recommendation – as not all of these women will develop GDM or need pharmacotherapy
- If a woman is taking an oral hypoglycaemic other than metformin she should contact the prescribing Doctor once pregnancy confirmed.
- Oral hypoglycaemics should be ceased 1-2 weeks prior to OGTT being performed
- Oral hypoglycaemic use for first trimester miscarriage prevention is still not conclusive and should not routinely be continued on these grounds ^{11, 12}.

High Risk Factors for Gestational Diabetes Mellitus (GDM)

A 75g 2 hour Oral Glucose Tolerance Test (OGTT) should be performed at the earliest opportunity once pregnancy confirmed in those women with the following risk factors.

- Ethnicity: Aboriginal/Torres Strait Islander, Asian, South Asian, Pacific Islander, Maori, Middle Eastern, non-white African
- Insulin resistance (e.g. associated with PCOS)
- Maternal age ≥ 40 years
- Medications e.g. corticosteroids, antipsychotics
- Periconception or initial booking BMI ≥ 30
- Previous adverse pregnancy outcome suggestive of undiagnosed GDM e.g. shoulder dystocia, unexplained stillbirth
- Previous baby with birth weight $> 4.5\text{kg}$
- Previous GDM
- Strong Family History Diabetes (e.g. first degree relative with diabetes; or sister with GDM)

If the test is negative, a 75g 2 hour OGTT should be repeated in these women at 26-28 weeks gestation.

Routine GDM Screening

ALL other women should have 75g 2 hour OGTT at 26-28 weeks gestation

Oral glucose tolerance test (OGTT)

- There is no need for a 3 day high carbohydrate diet before the OGTT.
- Advise the woman that:
 - The 75g OGTT will take over 2 hours and that she must stay at the laboratory during that time.
 - The OGTT is performed in the morning: a fasting blood glucose level (BGL) is performed and then an oral glucose load of 75g is given in the form of a drink. A further BGL is performed at both 1 hour and 2 hours post glucose load.

- Vomiting at time of OGTT:
 - If patient vomits at time of 75g OGTT, look at other risk factors.
 - If in high risk category refer patient to DE to monitor BGL for one week.
 - If low risk - offer repeat test or refer patient to DE to monitor BGL for one week.
- False Negatives:
 - False negatives may be identified by examining risk level of patient
 - If clinical features are suspicious of GDM despite negative test, refer to DE for BGL monitoring

7.3 DIAGNOSTIC CRITERIA FOR GESTATIONAL DIABETES MELLITUS (GDM)

GDM should be diagnosed if one or more of the following criteria are met:

- Fasting BGL ≥ 5.1 mmol/l
- Random BGL ≥ 11.1 mmol/l (i.e. beyond 2 hours postprandial)
- OGTT results
 - Fasting BGL ≥ 5.1 mmol/l
 - 1 Hour BGL ≥ 10.0 mmol/l
 - 2 hour BGL ≥ 8.5 mmol/l

7.4 ANTENATAL MANAGEMENT

Referral

All patients with a positive result must be referred promptly (preferably within a week) to the Diabetes Educator (DE) and Dietitian.

It is recommended that diabetes and antenatal care are delivered through multidisciplinary clinics where possible to minimise the number of separate appointments that the patient has to attend, hereby improving patient attendance and compliance and improving coordination of care and management.

Individualised clinic appointments may be necessary due to language or other needs.

A woman newly diagnosed with GDM should have access to resources for patient information in a format that are culturally and health literacy level appropriate

Once GDM is diagnosed the patient requires review as indicated in Table 1 (Page 6).

Gestational Diabetes Mellitus Management Policy

SESLHDPD/282

Table 1: Antenatal Management of Women with GDM

This is a guideline only and all other obstetric and medical risk factors must be taken into account for each woman

GDM Management			
Activity	Oral hypoglycaemic medication or insulin	Diet Not well controlled	Diet Well controlled
1. Review by Diabetes Educator (DE)	Diagnosis then 1-4 weekly		
2. Review by Dietitian	Diagnosis then as required		
3. Review by Endocrinologist or Obstetric Physician	<ul style="list-style-type: none"> Diagnosis (1-2 weeks post DE/Dietitian) Commencement of pharmacotherapy and then 1-4 weekly 	<ul style="list-style-type: none"> Diagnosis (1-2 weeks post DE/Dietitian) At recognition of poor control and then 1-4 weekly 	<ul style="list-style-type: none"> Diagnosis (1-2 weeks post DE/Dietitian)
4. Review by Obstetric ANC	Commencement of pharmacotherapy	Recognition of poor control	Stay with low risk model of care
5. Obstetric Model of Care	Obstetric ANC	Obstetric ANC	Diabetes team and low risk model of care (MGP, GPSC, other)
6. Morphology Ultrasound	Usual care	Usual care	Usual care
7. Fetal Echocardiogram	Not required	Not required	Not required
8. Ultrasound Surveillance	Once on treatment every 4-6 weekly in 3 rd trimester	Consider 4-6 weekly in 3 rd trimester	Not required
9. HbA1C/Fructosamine	Consider 4-6 weekly	Consider 4-6 weekly	Not required
10. Administration of Corticosteroids	<p><u>On Insulin:</u></p> <ul style="list-style-type: none"> Consult Endocrinologist/Obstetric Physician for plan Continue QID BGL Increase in insulin dose at time of first dose of corticosteroids if required and review dose after 24 hours Continue for 48 hours after first dose of corticosteroids and then return to usual insulin dose No change to meal time insulin <p><u>On Oral Hypoglycaemic Medication:</u></p>	<ul style="list-style-type: none"> Consult Endocrinologist/Obstetric Physician for plan Continue QID BGL Consider temporary treatment with insulin for 48 hours, especially if woman demonstrates hyperglycaemia after the first dose of corticosteroids 	

Gestational Diabetes Mellitus Management Policy

SESLHDPD/282

GDM Management			
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11. Antenatal Colostrum Expression	Education and consultation by appropriately trained practitioner, ideally a midwife or lactation consultant by 36 weeks gestation for commencement of expression and storage of colostrum ^{14,15,16}		
12. Timing of delivery	<p><u>40-41 weeks:</u> Well controlled on low dose insulin(<0.5 U/kg current weight)/oral hypoglycaemic medication with no other obstetric risk factors</p> <p><u>By 40 weeks:</u></p> <ul style="list-style-type: none"> Poorly controlled on insulin/oral hypoglycaemic medication High dose insulin (>0.5 U/kg current weight) requiring GDM Insulin/oral hypoglycaemic medication with other obstetric/medical risk factors 	Aim to deliver by 40 weeks	<p>Consult with low risk model of care obstetrician (MGP/GPSC/other) at 40 weeks</p> <p>Usual postdates if no other obstetric risk factors</p>
13. Follow up Baby	<p>Recommend and support exclusive breastfeeding¹⁵</p> <p>Recommend breastfeeding</p> <p>Ensure any expressed colostrum accompanies the mother and is readily available for use if required.</p> <p>Encourage rooming in on postnatal ward to limit separation of mother and baby, unless medically indicated as per SESLHD Policy (SESLHDPD/158)¹⁷</p> <p>Arrange monitoring and management for neonatal hypoglycaemia as per the Hypoglycaemia in a neonate - monitoring and management local operating procedure (SGSHHS¹⁸, RHW¹⁹)</p>		

Roles in the Multidisciplinary Team (MDT)

Diabetes Educator

- Provide general education about the nature of diabetes in pregnancy
- Enrol women in National Diabetes Services Scheme (NDSS)
- Instruct the patient in the techniques of blood glucose monitoring four times a day (QID) i.e. fasting and 1 or 2 hour postprandial
- In some cases, the patient will require insulin therapy which will be prescribed by the physician and the patient will be given instruction on self-administration of insulin
- Educate insulin treated patients about hypoglycaemia
- Educate women about the benefits of breastfeeding for women with diabetes and encourage breastfeeding

Dietitian

- Educate patients about the appropriate diet for managing their diabetes
- Provide information on appropriate weight gain during pregnancy
- Ensure adequate and balanced diet during pregnancy
- Outline basis of long term healthy eating for reducing risk of diabetes in the future

Endocrinologist/Physician*

- Initial consultation with woman with GDM within 1-2 weeks of seeing the Diabetes Educator and Dietitian
- Explain results of Diabetes testing and plan target blood glucose levels (BGL)
- Explain potential maternal and fetal/neonatal complications
- Advise about the potential long term implications of diabetes
- Describe the management regimen during pregnancy and with birth
- Perform an appropriate history and examination
- Identify and manage any maternal complications (e.g. hypertension, renal impairment, eye disease)
- Ensure review at least every 4 weeks (these reviews can be done by Diabetes Educators or GPs in diet controlled or low risk)
- Ensure liaison with obstetrician/midwife/GP performing antenatal care
- Refer to obstetrician if insulin or oral hypoglycaemic medication are commenced or diabetic control is considered sub-optimal.

**with appropriate education and resourcing this could be the role of the Antenatal shared care GP for low risk diet controlled GDM.*

Midwife

- All women should have access to midwifery education and support throughout their pregnancy
- Women who are diet controlled (with no other obstetric risk factors) and have good diet control are at no greater risk obstetrically; therefore this group do not need to be managed in a medical model of care and can remain in midwifery/GP model¹⁰.
- Ensure those who commence pharmacotherapy, are non-compliant or don't have good control, and/or have additional risk factors are referred to Endocrinologist/Obstetric Physician **and** Obstetric ANC

Obstetrician

- Initial consultation with woman with GDM who requires Insulin/Oral hypoglycaemic pharmacotherapy, are non-compliant or who don't have good diet control
- Follow up consultations regularly as per antenatal care schedule
- Explain the potential maternal and fetal/neonatal complications of GDM requiring pharmacotherapy or poorly controlled GDM
- Organise any additional obstetric investigations needed
- Review regularly as per antenatal care schedule
- Assess timing of delivery for women on insulin/oral hypoglycaemic pharmacotherapy, or suboptimal control evidenced by elevated BGL, fetal complications or other obstetric indications

Treatment Targets

An individual's range of acceptable BGL may vary according to other risk factors. The individualised range for each woman should be communicated to the patient and the rest of the MDT via the patients BGL diary or recording sheet as per the local clinical procedure.

The following self-monitoring treatment ranges are suggested, though advice should be sought from the Endocrinologist/Obstetric Physician/Diabetes Educator.

- Fasting capillary blood glucose (BG): ≤ 5.0 - 5.5 mmol/L
- 1 hour BG after commencing meal: ≤ 7.4 - 8.0 mmol/L
- 2 hour BG after commencing meal: ≤ 6.7 - 7.0 mmol/L

Administration of steroids to women with diabetes

Administration of steroids for fetal lung maturation to women with diabetes is associated with an increase in blood glucose levels.

For management details see **Table 1; Section 10: Administration of Corticosteroids**

7.5 INTRAPARTUM MANAGEMENT OR PRE-CAESAREAN REGIMEN FOR WOMEN WITH GDM

If planned (elective) Caesarean Section, ensure booked on a morning operating list (no need to admit the night before).

All women with diabetes in pregnancy require a detailed diabetes management plan for the time of delivery, taking into account the mode and timing of delivery is unpredictable (table 2). This should include details about management in the immediate post-partum period and follow up arrangements (example Appendix A).

Table 2: Intrapartum or Pre-Caesarean Regimen for Women with GDM

<p>Diet Controlled GDM</p>	<ul style="list-style-type: none"> • Continue with normal BGL regime until fasting or in established labour • Women with diet-controlled diabetes continue with normal BGL regime until in labour • Perform one blood glucose level (BGL) on admission to Delivery Suite (DS) - no intervention if BGL 4.0-8.0 mmol/L • Continue 6hourly BGL testing and a diabetic diet • Insulin will rarely be required at this stage of pregnancy • If BGL <4.0mmol/l or >8.0 mmol, treat as per sliding scale in section 7.6 • No 5% dextrose is required
<p>Oral hypoglycaemic medication</p>	<ul style="list-style-type: none"> • Continue with normal BGL regime until fasting or in established labour • Cease oral hypoglycaemic medication at commencement of established labour or when fasting commences • Perform blood glucose level (BGL) on admission to Delivery Suite, and 2 hourly throughout established labour • Perform BGL hourly from 0600hr for planned (elective) CS • If BGL <4.0 or > 8.0 mmol/L, treat as per sliding scale in section 7.6
<p>Insulin Therapy</p>	<ul style="list-style-type: none"> • Continue usual dose of insulin until fasting or in established labour • Continue with normal BGL regime until fasting or in labour • Perform blood glucose level (BGL) on admission to DS, and 2 hourly throughout established labour • Perform blood glucose level (BGL) hourly from 0600hr for planned (elective) CS • When in established labour, initiate continuous electronic fetal monitoring • Notify Paediatric Team/Special Care Nursery if neonatal admission is anticipated • Maintain accurate fluid intake and output chart • If BGL <4.0 or > 8.0 mmol/L, treat as per sliding scale in section 7.6

7.6 INSULIN THERAPY IN LABOUR OR DURING CAESAREAN SECTION

This can be given by:

1. Sliding scale subcutaneous route
2. Intravenous infusion +/- concurrent dextrose infusion

SESLHD POLICY

Gestational Diabetes Mellitus Management Policy

SESLHDPD/282

Sliding Scale¹³

BGL mmol/l	Action
0 - 3.9	No insulin, give carbohydrate meal or commence 5% dextrose 84ml/hr and continue until the patient is eating
4.0 - 8.0	No insulin, no 5% dextrose
8.1 - 10.0	6 units rapid acting insulin analogues s/c or as directed by endocrine team/obstetric physician
> 10	Consultation with endocrine team/obstetric physician and either continue with s/c insulin OR consider an insulin infusion and concurrent dextrose infusion as required

7.7 POSTPARTUM AND LONGER TERM FOLLOW-UP

- Consult individualised care plan (Appendix A) for individualised advice on:
 - BGL monitoring and any required pharmacotherapy in the immediate postpartum period
 - Recommendations and timing for further testing
 - Recommendations and timing for postnatal follow up appointments with Diabetes Team
- Ensure contraception plan in place for women with suspicion of ongoing diabetes OUTSIDE pregnancy – to be reviewed by Obstetric JMO prior to discharge
- All women with GDM should have a 75g OGTT, preferably 6-12 weeks post-partum
- Annual check with GP (annual cycle of care) - this should be included in hospital discharge information to GP. Regular surveillance for the development of Type 2 DM²⁰

7.8 FUTURE DIRECTION

- a) GP Antenatal shared care
 - For diet controlled uncomplicated GDM
- b) Referral pathways
- c) mHealth and eHealth opportunities (e.g. GDM app for mobile phones)
- d) Audit maternal and neonatal outcomes annually-see RHW audits

8. DOCUMENTATION (include links to relevant procedures/forms)

- Integrated clinical notes
- ObstetriX
- Antenatal card
- Partogram
- Postnatal Clinical Pathway
- Neonatal Care Plan

9. REFERENCES

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10. REVISION & APPROVAL HISTORY

Date	Revision No.	Author and Approval
October 2014	0	Draft policy developed
December 2014	0	Endorsed by SESLHD Clinical and Quality Council



SESLHD POLICY

Gestational Diabetes Mellitus Management Policy

SESLHDPD/282

APPENDIX A: Care plan for diabetes management for patients in Labour or prior to Caesarean Section and post-partum

Date

To the Midwife / Registrar /

RE:

This patient has: gestational diabetes / pre-gestational NIDDM / pre-gestational IDDM

She is being treated with: diet alone / diet and insulin / diet and oral hypoglycaemics / oral hypoglycaemics and insulin.

On the evening prior to induction or CS she should receive the following:

- Usual dose of insulin or oral hypoglycaemics until in established labour or fasting
- Or
- The following :

Her diabetic condition places this baby at LOW/HIGH risk of neonatal complications

She will / will not require 5% dextrose 84 ml/hr, from 0600 hours

During labour / CS she should have her capillary blood glucose checked hourly /qid

If the BGL is <4.0 mmol/l or >8.0 mmol/l, please follow Appendix B of the Diabetes protocol.

1. sliding scale of insulin and dextrose
2. insulin infusion and dextrose

OR:

Institute the following treatment:

Contact

After delivery she should continue BGL testing hourly / qid for days with diet.

- She should commence the following dose of insulin when able to eat :.....
- This patient will / will not require a repeat 2 hour GTT at.....weeks post partum.
- This patient will / will not require an appointment for the Diabetes Clinic in weeks.

Yours sincerely

.....