**Managing glucose levels using Multiple Daily Injections (MDI) through labour or C-section**

* Glucose should be checked and recorded hourly on the blue sheet. This can be sensor glucose. However, if the sensor glucose is out of target range 4-7 mmol/l a capillary blood glucose level should be checked before action is taken. In addition, capillary blood glucose should be checked at least 4 hourly.
* The woman should continue her usual basal infusion rates and give correction doses using individualised ISF (insulin sensitivity factor) and target 5 mmol/l.
* Target glucose range 4-7 mmol/l.
* If glucose remains above 8 mmol/l despite giving correction doses following the protocol, an individualised VRII (plus glucose) should be started and correction injections stopped.
* If the woman or birth partner is unable or unwilling to manage MDI an individualised VRII (plus glucose) should be started and correction injections stopped.
* Immediately after birth, basal rates should be reduced to the planned postpartum basal rates. As soon as possible after birth (and certainly before the first bolus) the woman MUST change the bolus calculator settings to her postpartum settings.
* If the VRII plus glucose is used, insulin rates should be halved at birth.

**Managing glucose levels using MDI through planned caesarean birth**

Women who are fasting overnight prior to a planned caesarean birth are advised to check their glucose at 3am and on waking in the morning and take corrective action if glucose out of target range 4-7 mmol/l. Hypoglycaemia should be treated with oral quick acting carbohydrate, and women should inform the anaesthetist if this has been necessary. On the morning of the planned caesarean, the protocol in figure 1 should be followed from waking.

**Responsibilities of staff, the woman and her birth partner for women continuing MDI through birth**

The key to successful use of MDI during labour, or prior to caesarean, and birth is to have a clear protocol which all staff on the labour ward are aware of, including not only the obstetric staff but other staff who may be involved, such as anaesthetists. The birth partner should be closely involved in planning for what is going to happen at the time of birth so that they are able to manage the pump, if needed.

While the woman remains on MDI, the woman and her birth partner are responsible for checking and documenting glucose hourly, giving correction via injections. The midwife is responsible for ensuring the woman / birth partner remains able and willing to manage this, that glucose is checked and documented hourly, and that if glucose is persistently (see below) above 8 mmol/l, VRII plus IV glucose is started and the correction injections are stopped. If the woman is on VRII plus glucose, the midwife is responsible for checking capillary blood glucose (NOT sensor glucose) hourly and adjusting VRII rates as prescribed.

