Diabetes mellitus (DM) is an important comorbidity among hospitalized inpatients. Among the more than 50,000 admissions to our 1,500 bed tertiary acute care hospital in 2015, more than 30% were documented to have DM.

Within the last 5 to 10 years, establishment of a number of guidelines\textsuperscript{1-2} has given greater impetus for clinicians to achieve good inpatient glycaemic control. At the same time, tight inpatient glycaemic control is associated with an increased risk of hypoglycaemia, which has been associated with adverse outcomes, such as length of stay, inpatient mortality and early readmission\textsuperscript{3}.

Achieving good inpatient glycaemic control without increasing the risk of inpatient hypoglycaemia is a complex task. The use of a standard template is unlikely to be successful because of the contextual nature of many of the interventions. Each hospital and ward needs to spend time to find the best approach for their unique situation.

Some essential components in a system seeking to reduce inpatient hypoglycaemia\textsuperscript{4} include:

1. Standardised prescribing and monitoring
2. Matching nutritional intake to dosing of anti-diabetic medications
3. Comprehensive education programs for staff
4. Patient and family education

All these components require coordination and communication between multiple stakeholders. Support from both senior management and ground leaders is also essential.

Strategies undertaken to ensure successful implementation, spread and sustainability include:

1. Adoption of the Institute of Healthcare Improvement (IHI) improvement methodology in describing our aims, measures and action plans.
2. Effecting change management through building of will, facilitating ground-up ideas for change and implementing a system to support continuous learning and strong execution of ideas.
3. Adopting IHI’s Framework for Spread to guide design of a process for effective and sustainable spread across units.

References
