GUIDELINES FOR THE INPATIENT TREATMENT OF INSOMNIA IN ADULTS – version 4

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KEY GUIDELINE ISSUES:

1. Details preferred choice of drugs
2. Provides authority to stop unused ‘as required drugs’
3. Details the need for consultant support of regular use and use after discharge of benzodiazepines started in hospital
4. Details the need for good communication with GPs after discharge

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The prescribing of hypnotics is widespread. Tolerance and dependence to their effects is likely after the patient has been taking the drug for no more than a few weeks. The use of benzodiazepines has been associated with a 50% increase in hip fractures in older people1. To minimise the risk of such problems developing, the following standards should be applied wherever appropriate.

1. When patients are admitted to hospital from the community and are already taking a Z drug or benzodiazepine hypnotic, it should not automatically be assumed this is established treatment as it may only have been started within the last few days to cope with the crisis.

2. If the patient is on a Z drug or benzodiazepine hypnotic on admission, it should be established when it was started. If this cannot be done on admission it must take place at the first ward review. If it was initiated in the four weeks prior to admission and the intention is to continue prescribing it for the time being, the ‘Original start date’ box on the drug chart must have the approximate start date of the drug recorded rather than the usual term ‘Before admission’, to indicate it was recently started.

3. Part of the assessment of the patient should be to review their use of hypnotics and whether their continued use is indicated. An in-patient stay is often the most suitable time to make changes to medication, whilst the patient is in a supportive environment with prescribers, nurses and other therapists on hand to help the patient reduce or stop their hypnotic.

4. Consider providing advice on good sleep hygiene. For example, relaxation techniques, avoiding daytime napping, and avoiding caffeine after lunch and alcohol, nicotine, heavy meals or vigorous exercise in the evening. Older people should be given reassurance that 5-6 hours sleep is usually adequate for them. Counselling can be considered and CBT has also been shown to be beneficial.

5. Junior doctors should not routinely initiate hypnotics on admission. If following assessment an MDT decision is made to treat acute insomnia, medicines should be used for short-term relief only where the insomnia is severe, disabling or subjecting the individual to unacceptable stress.

6. Unless the patient was admitted on regular doses of night sedation, hypnotics should only be prescribed on the 'as required' section of the prescription chart unless the use of regular doses is supported by the documented recommendation of a consultant.

Consideration must be given to the potential causes of insomnia – these include:

- External factors e.g. light, noise.
- Physical problems e.g. heartburn, dyspnoea, restless legs, night cramps.
- Physiological disturbance e.g. shift work, daytime napping.
- Psychological factors e.g. anxiety, depression.
- Substance misuse.
- Inadvertent stimulant use e.g. caffeine, nicotine and some over the counter medicines or prescribed medicines.
7. When initiating hypnotics the prescription should be for a maximum of two weeks, with a clear stop date written on the prescription. A clear note must be made in the clinical notes detailing why the hypnotic was started and for how long it is intended to continue or what the review date is.

8. The first-line hypnotic in the over 65s is zolpidem because of its shorter action, which reduces the risk of hangover effects that can increase the risk of falls. In working age adults either zolpidem or zopiclone can be used, though zopiclone may impair driving performance more than shorter acting drugs and it can also leave a metallic taste in the mouth. Temazepam is a popular drug of abuse and, as it is a controlled drug, its use increases nursing time and paperwork. Where a benzodiazepine hypnotic is required, loprazolam may be considered. It is short acting and not a controlled drug, though it is significantly more expensive than the Z-drugs. Lormetazepam should not be used as it is very expensive and offers no significant advantage over other benzodiazepines.

9. NICE recommends that patients who have not responded to one Z-drug, (e.g. zolpidem), should not be prescribed another, and that switching between Z-drugs should only occur if a patient experiences adverse effects that could be attributed to a particular product, e.g. metallic taste with zopiclone. However because of the higher risk of hangover effects with zopiclone, patients over 65 admitted on zopiclone who continue to need hypnotics, should be switched to zolpidem and only restarted on zopiclone if there is a good clinical reason to do so. Working age patients already on zopiclone should be offered the opportunity to switch, to minimise hangover effects and remove the metallic taste, if they suffer from it.

10. Melatonin (Circadin®) 2mg modified release tablets, can be prescribed for up to 13 weeks in insomnia. It is only licensed for use in the over 55s.

11. Chloral preparations are not recommended for use in the BNF. Chlomethiazole may sometimes be considered for use in older people, but not first-line.

12. Whilst not a recommended option in the BNF, promethazine is licensed for the short-term treatment of insomnia in adults. However, it should be noted that it is long-acting and therefore often causes morning hangover effects, and is anti-cholinergic therefore less suitable for use in the elderly.

13. In very exceptional circumstances, there may be an identified need for a longer-acting hypnotic, such as nitrazepam, for patients who suffer from early morning wakening, (or frequent wakening). This drug may be less likely to cause rebound insomnia and may also have a next-day anxiolytic action. However, next-day sedation is more likely to occur. Consideration must also be given to the potential for plasma levels to accumulate – this is especially in older people and may be associated with an increased risk of daytime drowsiness, ataxia and falls. Nitrazepam should not be considered for routine use.

14. If a patient is admitted on a long-acting hypnotic, eg. nitrazepam, the inpatient admission can be used as an opportunity to re-assess the need for this medicine, particularly in older people.

15. When writing up the ‘as required’ hypnotic the prescriber must:

- Discuss with the patient the benefits of avoiding the use of and minimising the dose of hypnotics.
- Discuss the principles of good sleep hygiene.
- Endorse the additional information box with the statement ‘For insomnia’ and if appropriate state a suggested time period when an ‘as required’ dose may be administered.
- Use the lowest effective dose.
- Consider the use of intermittent dosing, e.g. alternate nights, or less.
• Consider the risk of hangover, confusion, ataxia and falls in older people.

16. Unless there is a prescribed administration time in the additional information box, nurses should only administer ‘as required’ hypnotics:

• After 11.30pm, after the patient has had an opportunity to fall asleep.
• No later than 1.00am in the morning to avoid hangover effects next morning.

• **For no more than 2 consecutive nights.**

This guidance can be overridden, but the medical team must be asked to review the patient the next day.

17. Under normal circumstances nurses should not offer ‘as required’ hypnotics to patients. They should only be administered ‘on request’, only once the nurse is satisfied that appropriate attempts to relax and sleep have been made, and only in accordance with the guidance given above. (See 10).

18. Any patient written up for an ‘as required’ hypnotic should have their prescription cancelled if no dose has been administered in the previous two weeks. Pharmacy staff have the authority to cancel such prescriptions.

19. All ‘as required’ hypnotic prescriptions should be regularly reviewed, eg. at weekly ward rounds, to assess frequency and appropriateness of usage.

20. No patient should be discharged from hospital on a hypnotic unless:

• He or she was established on long-term treatment at least 4 weeks before admission

  or

• Continued use is supported by the documented recommendation of a consultant psychiatrist.

  If longer term use is envisaged (greater than 4 weeks) then consent needs to be obtained on use outside the product licence.

21. If the GP is expected to continue to prescribe a hypnotic initiated during or within the four weeks prior to admission, he or she must be provided with full details on why the medicine needs to be continued after discharge, how long the treatment is expected to be needed for, the dose and full details of any reducing regimen, and what information has been given to the patient or carer. If the use is unlicensed some GPs may refuse to take over the prescribing.

22. The use and problems associated with benzodiazepines and Z-drugs should be discussed fully with the patient, and the carer if appropriate. Patient leaflets on the subject are available.

Additional information

1. Where patients have been taking benzodiazepines (or a Z-drug) for any length of time, withdrawal should be undertaken with care. The withdrawal syndrome can be severe. If patients present with benzodiazepine dependence but with a more complex problem than usually encountered obtain advice from your local Substance Misuse Service.

2. If the patient is taking other medicines that cause drowsiness, the administration should be timed, where possible, to allow the onset of drowsiness to coincide with the planned sleep time. This might apply to antidepressant and/or antipsychotic medication, although these medications should not be used solely for the treatment of insomnia.

3. Consideration should be given to the risk of benzodiazepines causing a paradoxical increase in aggression in some patients.
4. Where possible, hypnotics should be avoided in patients with pulmonary insufficiency, significant respiratory depression, obstructive sleep apnoea or severe hepatic impairment, and in those patients who may be prone to addiction. Particular caution should be used in those patients with personality disorders.

5. Printed information is available on sleep hygiene and individual hypnotics.

References
