Frequently Asked Questions on the New Inpatient Hypnotic and Benzodiazepine Anxiolytic Guidelines – version 2

1. Why do we need these guidelines?

There have been a number of initiatives, both locally and nationally, to reduce the use of benzodiazepines and hypnotics due to a range of potential problems they can create, particularly addiction, impaired cognitive function and hangover effects, leading to increased risks of falls and accidents.

An audit several years ago in one locality showed that introducing similar inpatient guidelines resulted in a very significant reduction in all hypnotic prescribing and in the administration of ‘as required’ hypnotics per prescription written.

GPs have also fed back concerns about hypnotics and benzodiazepine anxiolytics being started in hospital and continued after discharge for no apparent reason, or are stopped at discharge after the patient has become dependent on them such that the patient rushes to the GP demanding they be restarted.

We also need to identify patients started on these drugs just prior to admission and treat them as though started during admission. Ascertaining when the hypnotic or benzodiazepine was started needs to be done at the first review if not done on admission.

2. Why have time constraints been put in the guidelines for administering ‘as required’ hypnotics?

Individuals need to be given the opportunity to go to sleep without hypnotics, and offering them too early may hinder the development of natural sleep patterns and encourage dependence. Alternatively, giving hypnotics too late can lead to hangover effects the next day.

3. Why are you expecting ‘as required’ hypnotics to be given for a maximum of two consecutive nights?

This minimises the risk of addiction and dependence on hypnotics. Patients who have received regular hypnotics on wards and then go home and try to manage without them are at much greater risk of rebound insomnia. This can lead to GPs restarting hypnotics.
4. **What happens if a patient insists on taking their 'as required' hypnotic earlier than 11.30pm or for a third consecutive night?**

The guidelines allow for this, but there is an expectation that the hypnotic prescription be reviewed the next day by the team and discussed with the patient. The prescriber can provide specific advice on the Drug Chart in the ‘Additional instruction’ box e.g. “If requested by the patient, the dose can be given at 10.30pm.”

5. **Why does the consultant have to document in the patient’s notes, their support to start regular hypnotic treatment?**

Introducing regular hypnotic treatment significantly increases the risk of the patient becoming dependent on hypnotics. Involving the consultant minimises the risk of regular hypnotics being inadvertently started.

It is also important that if regular hypnotics are started and the intention is to stop them when the patient leaves the ward, every attempt is made to do this prior to discharge. The patient will need to be warned that some rebound insomnia may occur. If discontinuation of the regular hypnotic cannot start until after discharge then clear advice must be given to the patient (or carer) and the GP on how to gradually discontinue the hypnotic.

6. **Why is lorazepam in the under 65s only recommended for ‘as required’ acute severe agitation?**

Lorazepam is a short acting benzodiazepine with a much higher incidence of withdrawal problems if addiction occurs. Diazepam's long half life is much better suited to regular use and ‘as required’ use for severe anxiety.

7. **Pharmacists seem to have key role in stopping ‘as required’ hypnotics and benzodiazepines?**

Yes they do. Pharmacists have the authority to cancel ‘as required’ hypnotic prescriptions if no dose has been given for two weeks. Similarly, they also have the authority to stop ‘as required’ benzodiazepine anxiolytics after discussion with the ward manager.

8. **What happens to those started on and then assessed as needing long term hypnotics or benzodiazepines?**

Firstly this decision has to be agreed by the Consultant and the decision recorded in the notes by him or her. This includes not only those started on these drugs while on the ward but also those started on them just prior to admission. If the GP is expected to continue to prescribe the hypnotic or benzodiazepine, 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 regime, and what information has been given to the patient or carer.