GUIDELINES FOR THE INPATIENT USE OF BENZODIAZEPINE ANXIOLYTICS IN ADULTS – version 4

GUIDELINE REPLACED
Version 4 – October 15

RATIFYING COMMITTEE
Drugs and Therapeutics Group

DATE RATIFIED

NEXT REVIEW DATE

EXECUTIVE SPONSOR
Executive Medical Director

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KEY POLICY 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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Guidelines for the Inpatient Use of Benzodiazepine Anxiolytics in Adults - version 4

The prescribing of benzodiazepines 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 people. 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 benzodiazepine anxiolytic, 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 benzodiazepine anxiolytic 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 benzodiazepine anxiolytics 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 medication.

4. Consider providing advice on relaxation techniques. Also, suggest avoiding caffeinated drinks and alcohol. Counselling can be considered and CBT has also been shown to be beneficial.

5. Junior doctors should not routinely initiate ‘as required’ benzodiazepines for anxiety. If there is a history of aggression and severe agitation, ‘as required’ lorazepam can be written up for no more than two weeks with a clear stop date.

6. When treating acute anxiety, benzodiazepines may be used for short-term relief only where the anxiety is severe, disabling or subjecting the individual to unacceptable stress. The prescription should be written for a maximum of two weeks, with a clear stop date.

7. Unless the patient was admitted on regular doses of benzodiazepines they must 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.

8. When writing up an ‘as required’ benzodiazepine the prescriber must endorse the additional information box with a clear indication, to clarify when the medicine may be administered.

9. When initiating any benzodiazepine a clear note must be made in the clinical notes detailing why the benzodiazepine was started and for how long it is intended to continue or when the next review is due.

10. Any patient written up for an ‘as required’ benzodiazepine should have their prescription queried if no dose has been administered in the previous two weeks.
Pharmacy staff must discuss the continuing need first with nursing staff and, if indicated, may then discontinue it. If the ‘as required’ dose is for an infrequent specific event, e.g. a visit to the dentist, then this must be clearly stated under the indication.

11. All ‘as required’ anxiolytic prescriptions must be regularly reviewed, eg. at weekly ward rounds, to assess frequency and appropriateness of usage.

12. The short acting benzodiazepine, lorazepam, is the drug of choice if an ‘as required’ dose is prescribed for severe agitation. However if a benzodiazepine anxiolytic is needed following non-drug interventions, then diazepam may also be considered. Diazepam’s long half-life reduces the risk of withdrawal symptoms more commonly associated with short acting drugs like lorazepam and oxazepam.

13. In the over 65s the benzodiazepine anxiolytic of choice is lorazepam due to the risks of hangover effects, ataxia and falls being less than with diazepam. However, diazepam may be indicated for some older people. If so, the increased risks should be fully considered.

14. No patient should be discharged from hospital on a benzodiazepine unless:
   - He or she was established on long-term treatment at least four weeks prior to 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 may need to be obtained on use outside the product licence.

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

16. If the GP is expected to continue to prescribe a benzodiazepine anxiolytic 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.

Additional information

1. When patients are admitted to hospital from the community and are already taking benzodiazepines, it should not automatically be assumed these are appropriate. Part of the assessment of the patient should be to review their use of anxiolytics (and hypnotics) and whether their continued use is indicated. An inpatient 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 these treatments.

2. Where patients have been taking benzodiazepines 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.

3. Consideration should be given to the risk of benzodiazepines causing a paradoxical increase in aggression in some patients.
4. Where possible, benzodiazepines 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 also be used in those patients with a personality disorder.

5. Printed information is available on benzodiazepine anxiolytics.