THE A, B, C, D, E of F

Appropriate Prescribing of Oral Benzodiazepines in Patients Over the Age of 65
INTRODUCTION

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• Disclaimer: I did not develop or write the guideline we are discussing today but I applaud the efforts of those who did and am happy to promote its use in clinical practice.
• Although this guideline is around benzodiazepine use, its model could be adopted for many other high risk medications implicated in falls such as Opioids.
SITUATION

• The Appropriate Prescribing of Oral Benzodiazepines in Patients over the Age of 65 Clinical Guideline (HNELHD CG 14_06) was developed to provide guidance to staff about risks of harm to patients that may be attributed to inappropriate use of these agents.

• The need for such a guideline was recognised by the HNELHD Junior Medical Officer Quality and Safety Committee after concerns by JMO’s being requested to prescribe “sleeping tablets”
• In keeping with my A B C D E of F title……
BACKGROUND

A- APPROPRIATE

• The acceptable indications for benzodiazepines are:
  • alcohol withdrawal using the AWS guideline and documentation
  • seizure/epilepsy treatment
  • end of life care (Palliative Care Therapeutic Guidelines)
  • Peri-procedural sedation
  • formally diagnosed severe generalised anxiety
  • Parasomnia, REM sleep movement disorder
• Data has been analysed that shows that Benzodiazepines are often prescribed for indications not accepted as appropriate and, of concern, mainly for acutely unwell elderly patients
BACKGROUND

B-Benzodiazepines

- Benzodiazepines are sedative hypnotic agents that have literally been around for decades. Their use in psychiatry has been superseded by newer agents that are more specific treatment for psychiatric disorders.
- They potentiate the inhibitory effects of GABA in the CNS resulting in their anxiolytic, sedative, hypnotic, antispasmodic and seizure controlling effects.
- A meta analysis published in the BMJ found a mean increase in sleep of only 36 mins with a benzodiazepine versus placebo. Significant improvement in sleep occurred in only 1 in 13 patients. Conversely 1 in 6 patients had an adverse event (eg a fall)
BACKGROUND

C-Charting (prescribing)

• If benzodiazepines have a clear indication in an elderly patient, they should be prescribed at the lowest effective dose (titrate to effect) and the duration limited to the clinical need.

• Consideration should be given to a short or medium acting agent and a time for review documented.

• Prescriptions should have the indication completed on the chart to prevent continuation past clinical need.

• National Standard 4.5,4.11
BACKGROUND

D-Deprescribing

• Just as important as prescribing is describing. Stopping long-term (therapy of longer than 2 weeks) benzodiazepines can be dangerous and the procedure for ceasing is outlined in the clinical guideline “Benzodiazepine Withdrawal” (HNELHD CG 11_19).

• If withdrawal is not possible during admission, a reduction plan should be considered and included in the discharge summary.
BACKGROUND

E-Elderly

- Elderly patients (>65 years of age) are more sensitive to the effects and side effects of benzodiazepines. Often they have been prescribed these medications for years (my record is a 95 year old taking Oxazepam for 50 years).

- Because of their altered metabolism of the drug and age related CNS changes they are more likely to have cognitive impairment, delirium and falls.
BACKGROUND

F-Falls

• Self explanatory. Medications are thought to be a causative factor in up to 25% of falls requiring admission to hospital. Benzodiazepines are in the psychotropic drug class listed in the Falls Risk Assessment Management Plan

• “Remember, no risk factor for falls is as potentially preventable or reversible as medication use” (Liepzig et al 1999)

• With that in mind it is easy to see why this guideline is so important in influencing good clinical practice.

• National Standard 10.1,10.2 and 10.3
The JMO Safety Committee conducted an audit of benzodiazepine prescriptions in patients over the age of 65 prior to the introduction of the guideline and again at six months post introduction. Both audit groups contained 90 patients. Benzodiazepine prescriptions were further divided into agent specific data (e.g., Temazepam).

The results were quite dramatic.

Prior to the introduction of the guideline, only 30.2% of prescriptions were for appropriate clinical indications. Of note, the majority of inappropriate prescriptions were for temazepam.

Post introduction the figure had more than doubled to 66%.

Although not available, it would be interesting to do a retrospective study on falls in this same period.
ASSESSMENT

• The JMO Quality and Safety Committee will continue to be advised of results of benzodiazepine audits. These audits will be completed regularly as part of high risk and accountable drug audits. (The clinical audit tool is attached to the guideline as an appendix)

• Statistics on frequency of request for sedative prescribing will be audited from the MON and use may be tracked from each ward to identify trends and inter-ward variances.
RECOMMENDATION

• In patients over the age of 65, benzodiazepines should only be prescribed in the presence of a clear indication or as continuation of long term benzodiazepine therapy.

• If contraindications exist in a patient on long standing benzodiazepine therapy, reduction and withdrawal should be considered during the admission.
RECOMMENDATION

• The JMO safety committee will ensure education on this guideline to successive years of JMO’s and are developing an education package for nursing staff.

• There are plans to initiate a “sleep hygiene” program using alternative treatments for insomnia whilst in hospital that can be continued at home.
• And because everything is as easy as A, B, C there is a flow chart......
Acknowledgements

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References

- HNELHD Clinical Guideline for Appropriate Prescribing of Benzodiazepines in Patients Over the Age of 65
- Liepzig et al 1999 discussion paper
- British Medical Journal
- AMH
- Therapeutic Guidelines