Occasional Audit

Prescribing Practice and Policy for Hypnotics: A Model of Pharmacy Audit

D. N. W. GRIFFITH, M. ROBINSON

Summary
A problem of overprescribing of hypnotic medication ('sleeping tablets') was identified and quantified within a department of health care for older people in a district general hospital. Data on the volume of prescribing were obtained from computerized pharmacy records, and this information was supplemented by a retrospective survey of case notes of 100 patients. Sixty per cent of patients were prescribed a hypnotic at some stage during their hospital stay. Twelve per cent were prescribed a sleeping tablet on admission on an 'as required' basis but never took this medication, suggesting that such prescribing was becoming routine.

As part of an ongoing pharmacy audit within the department, a policy was implemented to try to improve prescribing habits. Following this, hypnotic prescribing fell, with the average monthly number of sleeping tablets prescribed falling from 2392 to 734. A further survey of 100 case notes showed overall prescribing had fallen to 25%, although 2% were still prescribed a hypnotic on admission but never took it.

Introduction
Hypnotics may be valuable in carefully selected situations. However, doctors may prescribe them more often than is necessary. People's expectations of sleep may be inappropriate: they may want lengthier periods than could realistically be expected, or wrongly estimate their time in sleep. This may lead to doctors prescribing sedatives as an easy way of dealing with insomnia [1].

In hospital practice, the problem may be compounded by nursing-staff expectations: pressure may be applied to junior doctors from this source to prescribe hypnotics. Drugs should only be prescribed if there are good indications and the Committee on the Safety of Medicines (CSM) states that 'Benzodiazepines should be used to treat insomnia only when it is severe, disabling or subjecting the individual to extreme distress' [2]. In older people there are additional hazards with hypnotics in that the plasma half-lives are prolonged compared with those found in younger people [3]. This may lead to more of a 'hangover' effect, which in turn may predispose people to falls, or may impair rehabilitation [4]. Finally, the use of hypnotics in hospital may be the start of hypnotic addiction [1].

On informal inspection, we became aware of excessive prescribing of hypnotics to in-patients. At the same time, local general practitioners commented on the frequency with which people were being discharged from hospital on hypnotics. We therefore undertook a study to quantify the scale of hypnotic prescribing and subsequently implemented measures designed to improve our prescribing habits.

Setting: The survey population was all patients on acute elderly care wards in a district general hospital, looked after exclusively by members of the elderly care team. At the time of the study, 103 patients were located on five wards wholly catering for older people, the remaining patients being on a variety of other wards. Virtually all patients were aged over 80 years.

Methods
Temazepam had been identified as the hypnotic which accounted for all newly commenced prescriptions for hypnotics within the hospital. Computer-held pharmacy records were used to quantify retrospectively for a 6-month period the numbers of temazepam tablets issued to our wards (this figure may be assumed to reflect drug usage closely as regular ward checks prevented significant overstocking) and also the number of discharge prescriptions for temazepam. A retrospective survey was also carried out of case notes on 100 patients recently discharged. We used the 100 most recently completed discharge summaries to identify patients and then gleaned further information from their case notes. We noted at what stage during the admission the hypnotic was prescribed and whether prescribed hypnotics were actually taken. Case-note analysis was also used to gain some information on the volume of hypnotic use but this was primarily sought from the pharmacy data, which were less prone to sampling error. In addition, a postal survey of general practitioners was done to check whether hypnotics were continuing to be prescribed for those patients discharged on such medication. These initial results indicated that hypnotic prescribing was frequently irrational and well in
excess of what might have been expected if there had been compliance with the CSM guidelines. Steps were therefore taken to rationalize and reduce the prescription of hypnoctics. These measures are detailed in the Appendix.

One year after the introduction of this new policy the surveys were repeated.

Results

The results of the pharmacy figures and the case-note survey are shown in Tables I and II. The pharmacy data provide the best quantitative information and show ward issues of temazepam tablets running at 32.5% of previous levels following the introduction of the new policy. Discharge prescriptions for temazepam were halved. The case-note survey, while on a much smaller sample, closely mirrors these results for reduction in discharge prescriptions. Many more people were found to be discharged on hypnoctics than were admitted on them before the introduction of the new policy, but after the introduction of the policy, admission and discharge prescription numbers were similar indicating that most people were leaving hospital on hypnoctics only if they had been taking them before admission.

Overall prescribing of hypnoctics during in-patient stay showed marked reductions after the new policy had been introduced. The levels of hypnoctic prescribing were originally high: 43% of patients were prescribed a hypnoctic on the day of admission. Twelve per cent of prescriptions for hypnoctics were written on the day of admission but never actually taken by the patient at any stage during admission.

Letters were sent to family practitioners of all those patients who were discharged on hypnoctics, and of the original 100 patients seven were identified as continuing to receive prescriptions for hypnoctics after discharge who had not been taking hypnoctics before admission.

Discussion

Various strategies are available for the management of sleep problems. Hypnoctics may provide one valuable means of relief, but their place needs to be carefully considered. We were not attempting to ban the use of hypnoctics within our practice—the fact that monthly ward issues of temazepam tablets were still running at 734 after the introduction of the policy indicates continuing usage—but the problem of inappropriate use of hypnoctics in hospital is well recognized both during hospital stay and on discharge [5, 6]. Having identified a problem, we tried to institute a more rational approach to the prescription of night sedation. The results of our audit showed some encouraging signs. The overall reduction in hypnoctic prescribing shown by the pharmacy figures is the most striking feature but the findings from the supplementary surveys complement the volume data. Not only was there a substantial reduction in prescribing (from 60% to 25%) but of the 25 patients in the latter survey who were prescribed hypnoctics at some stage, 15 had been taking sleeping tablets before admission, and of the remaining ten, seven were only started on hypnoctics later in their admission. This suggests that the prescription was in response to a perceived real need.

In the initial survey, 14 patients were discharged on hypnoctics who had not been on such medication before admission. Seven of these were continuing to receive sleeping tablets from their family doctors at the time of the survey. This confirms previous reports that continued hypnoctic use may be triggered by a hospital stay [5].

This audit has become a starting point for further audits of pharmacy-related topics and our practice now includes regular monthly departmental audit meetings with the principal pharmacist. Such a system is becoming more widespread [7].

References

2. Benzodiazepines, dependence and withdrawal symptoms. 
Current problems No 21. Committee on Safety of Medicines.


Authors' addresses
D. N. W. Griffith
Department of Health Care for Older People,
M. Robinson
Department of Pharmacy,
Mayday University Hospital,
Mayday Road,
Thornton Heath, Surrey CR7 7YE.

Received in revised form 20 May 1996

Appendix

Measures to implement Change

1. Departmental guidelines—a policy was agreed between pharmacists, nursing and medical staff on hypnotic prescribing:
   'Few people should be prescribed drugs for night sedation. Sleeping habits vary widely between different people, and patients, nurses and doctors may have unrealistic expectations. Sleep may be particularly difficult for the initial few nights in hospital but this does not constitute a reason in itself for prescribing hypnotics. Specific reasons for poor sleep should be sought (e.g. pain, breathlessness, urinary frequency) and treated appropriately. Confusional states may require separate management. It may be appropriate to continue night sedation in those already habituated on admission, but it is sometimes worth trying to use the admission to start weaning them off sedation.'

On those occasions when hypnotics are prescribed, they should not be used for longer than 2 weeks at a time as tolerance may start after 3–14 days of continuous use. No discharge prescriptions for hypnotics may be written without first discussing this with the registrar or consultant.'

Attention was also drawn to the CSM guidelines.

2. These guidelines were incorporated into induction notes for junior medical staff and highlighted at the commencement of their posts.

3. The policy was made explicit to the nursing staff, particularly night staff.

4. The guidelines were reinforced at departmental audit meetings with input from a pharmacist.

5. The impact of the policy was assessed by pharmacy survey of hypnotic prescribing and this information was fed back at the audit meetings.