

Use of hypnotic drugs in a learning disabilities hospital

Y. Kon, M. Jackson, R. Banerjee, B. Robertshaw and F. Dunne

A one-day audit in a learning disabilities hospital revealed 15 patients (9.4% of the hospital population) on hypnotic medication. Guidelines were then developed for the use of hypnotic drugs. An audit of hypnotic drug usage was repeated for the 12-month period of 1994 which revealed that five patients were started on hypnotics.

Insomnia is a common problem with an estimated prevalence of 30% a year in the general population (Shapiro & Dement, 1993). Prevalence estimates are even higher among women, older adults and patients with medical (Bixler *et al.* 1979) and psychiatric disorders (Berlin *et al.* 1984). Patients in psychiatric hospitals frequently have problems sleeping. Their psychiatric illness, psychological factors and being in unfamiliar surroundings which may be noisy and disruptive are factors which contribute to poor sleep.

Silverstone & Muijen (1987) in a survey of psychiatric hospital prescribing showed that nearly half of all patients received a hypnotic. Hypnotics are one of the most commonly prescribed group of drugs with 15 million prescriptions in Britain annually (Shapiro & Dement, 1993). Although pharmacotherapy is the most frequently used method for treating insomnia, their usefulness in the management of long-term insomnia is unclear. Hypnotics are addictive and contribute to sleep disturbance when used in the long term (Anonymous, 1985). This, together with the recognition of psychological factors in insomnia, has prompted the development of behavioural and cognitive treatment techniques. These treatment modalities have concentrated on modifying maladaptive sleep habits, reducing autonomic and cognitive arousal, altering dysfunctional beliefs and attitudes about sleep and educating patients about healthier sleep hygiene practices (Espie, 1993; Morin *et al.* 1994).

Audit cycle

Earls House Hospital is a learning disabilities hospital which had 160 beds in 1993, 30 being acute treatment, 40 continuing health care and

90 long-term residential. The number of long-term residential beds fell by 18 during 1994, reducing the total hospital population by 11%.

The aim of this audit was to prevent prolonged and unnecessary prescription of hypnotic drugs in the hospital. Standards for the project were drawn up to meet these aims. On one day in 1993, an audit was taken of the people who were taking hypnotic drugs for insomnia. Compliance with our standards was assessed and following the initial trawl, guidelines for the use of hypnotics were drawn up.

- (a) Hypnotic drugs may be considered for patients who have had three successive nights without satisfactory levels of sleep. Sleep hygiene factors should be considered prior to the prescribing of any hypnotic. These include a low intake of caffeine and alcohol, and a warm comfortable quiet environment conducive to sleep.
- (b) Hypnotic drugs prescribed should be:
 - (i) licensed for use as a hypnotic
 - (ii) a short-acting drug
 - (iii) prescribed regularly for a maximum of 10 nights
 - (iv) then prescribed as required for two weeks.
 - (v) if further medication is needed, the case should be reviewed by the consultant. If further medication was thought to be necessary, the case should rejoin the cycle at (iii).
- (c) Case note documentation should include:
 - (i) drug name, dose, start date, stop/review date
 - (ii) exclusion of obvious underlying causes e.g. psychological problems, anxiety, pain, physical illness, other drugs.

These guidelines were established over a period of several months by the clinical team through formal discussion and examination of examples of 'good practice' identified by a literature search e.g. Espie (1993). All new prescriptions for hypnotics had to follow these guidelines and an audit of compliance with these guidelines was undertaken for 1994. The cardex of all

patients admitted during 1994 were examined for prescriptions for insomnia. The case notes of identified patients were obtained for data extraction.

Findings

The initial one day trawl in 1993 revealed 15 patients who were receiving medication for insomnia (Table 1). The majority used drugs licensed as hypnotics and half were short-acting drugs. Only one patient was on the drug for less than four weeks. Documentation was generally poor. The clinical team responded to this audit by reviewing medication prescribed to these patients; weaning them off hypnotic medication and encouraging good sleep hygiene. Repeat prescriptions were only given after the guidelines for the use of hypnotics had been followed.

The second audit was undertaken after the guidelines were implemented. All new admissions had their sleep monitored using a sleep monitoring chart. If there was a problem with sleep, sleep hygiene factors were considered prior to the prescribing of any hypnotic. There were 75 new admissions for the 12-month period of 1994 but only five people were started on hypnotic drugs. There was marked improvement in practice demonstrated by the improved compliance with standards. In 60% (3 cases), subsequent as required medication was not limited to two weeks. This did not cause concern as the drug was only given once or twice a month.

Comment

The guidelines have increased the awareness of all staff to the causes and prevention of insomnia and improved our prescription practice of

hypnotics. A by-product of this audit has been that the nurses have to record the sleep routine of all new admissions. If a problem is identified, sleep promotion procedure is implemented. This may explain the low usage of hypnotics, even when it is written up as an 'as required medication'.

It is interesting that in the second audit, all five patients were started on temazepam. Temazepam is now a schedule 2 controlled drug (The Misuse of Drugs Act 1971 and The Misuse of Drugs Regulation 1985). It is exempt from special prescription requirements but is subject to safe custody requirements. Although misuse of temazepam is not a problem with us, it would be interesting to discover how prescribing practice will change with this.

We are pleased with the improved compliance with standards in the second audit even though some of the standards were increased. There is still room for improvement in documentation of exclusion of obvious underlying causes. It may be that this is being done but not documented. It is important that psychological factors for insomnia are investigated as they may be easily remedied.

The junior doctors who are responsible for the day-to-day prescribing change every six months and it can be difficult for standards to be maintained. However, in this hospital, there is a stable experienced nursing population who are able to promote the continued usage of guidelines and maintain quality. We plan to repeat this audit to see if standards continue to be maintained.

Acknowledgements

We wish to acknowledge the contributions made by Dr Hamdi, Dr Rai and nursing staff.

Table 1. Audit standard compliance

	1993	1994
Number of identified cases	15	5
Percentage of hospital population	9.4%	3.5%
(a) Prescription of drugs considered only after:		
(i) three successive nights without satisfactory levels of sleep	- ¹	60%
(ii) evidence that sleep hygiene factors considered	- ¹	60%
(b) Hypnotic drugs prescribed should be:		
(i) licensed for use as a hypnotic drug	87%	100%
(ii) a short acting drug	53%	100%
(iii) prescribed regularly for a maximum of 10 nights	- ¹	100%
(iv) then prescribed as required for two weeks	- ¹	40%
(v) evidence reviewed by villa doctor	- ¹	80%
(c) Case note documentation should include:		
(i) drug name, dose, stop/review date, start date	20%	100%
(ii) evidence of exclusion of obvious underlying causes	20%	60%

1. These guidelines were only introduced for the second audit and hence no data are available for 1993.

References

- ANONYMOUS (1985) Some problems with benzodiazepines. *Drug and Therapeutics Bulletin*, **23**, 21-23.
- BERLIN, R. M. (1984) Sleep disorders on a psychiatric consultation service. *American Journal of Psychiatry*, **141**, 582-584.
- BIXLER E. O., KALES, A. & SOLDATOS, C. R. (1979) Sleep disorders encountered in a medical practice: a national survey of physicians. *Behavioural Medicine*, **6**, 1-6.
- ESPIE, C. M. (1993) Practical management of insomnia: behavioural and cognitive techniques. *British Medical Journal*, **306**, 509-511.
- MORIN, C. M., CULBERT, J. P. & SCHWARTZ, S. M. (1994) Nonpharmacological interventions for insomnia: a meta-analysis of treatment efficacy. *American Journal of Psychiatry*, **151**, 1172-1180.
- SHAPIRO, C. M. & DEMENT, W. C. (1993) Impact and epidemiology of sleep disorders. *British Medical Journal*, **306**, 1604-1607.
- SILVERSTONE, T. & MULJEN, M. (1987) Comparative hospital survey of psychotropic drug prescribing. *British Journal of Psychiatry*, **150**, 501-504.
- *Y. Kon, Consultant Psychiatrist, Oakwood, 22 Belle Vue Grove, Middlesbrough TS4 2PX; M. Jackson, Clinical Audit Coordinator; R. Banerjee, Consultant Psychiatrist; B. Robertshaw, Consultant Psychiatrist, Earls House, Lanchester Road, Durham DH1 5RD; and F. Dunne, Senior Registrar, County Hospital, North Road, Durham DH1 4ST

*Correspondence



Seminars in the Psychiatry of Learning Disabilities

Edited by Oliver Russell

This volume is both an up to date account of recent advances in the field of learning disabilities and a practical guide to the diagnosis and treatment of psychiatric disorder. Chapters on the classification of psychiatric disorders in people with learning disabilities, the epidemiology of intellectual disability and the diagnosis of psychiatric disorder are followed by more detailed accounts of autism, behavioural phenotypes and communication disorders. Psychiatric disorders are covered in the latter part of the book, including discussions on behavioural interventions, counselling and epilepsy. The book concludes with a review of forensic aspects of psychiatric management and treatment. 1997, 288pp, ISBN 0 901242 02 1, £15.00

The College Seminars Series and other Gaskell publications are available from Booksales, Publications Department, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG (Tel. +44(0)171 235 2351, extension 146). The latest information on College publications is available on the INTERNET at: <http://www.demon.co.uk/rcpsych/>