Partners in improving local health

North of England Commissioning Support

Care Bundle

Adult patients prescribed benzodiazepines or Z drugs

North of England Commissioning Support
Medicines Optimisation on behalf of Cumbria CCG

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1. Introduction

1.1. What is a care bundle?

A care bundle is a set of interventions that, when used together, significantly improve patient outcomes. The measures chosen reflect best practice and are based on NICE quality standards or other national guidance. Care bundles have been used extensively and successfully in Secondary Care, their use in Primary Care is more recent. This care bundle is based on the work of Healthcare Improvement Scotland and the Scottish Patient Safety Programme in Primary Care.

Reliability in health care is a failure-free operation over time. This equates to ensuring patients receive all the evidence-based care they are entitled to receive.

A care bundle is a structured way of improving processes of care to deliver enhanced patient safety and clinical outcomes. In relation to care bundles, this means ensuring that patients receive optimum care at every contact. The process for achieving reliability is to implement this set of measures (a care bundle). The key measure in a care bundle is the score which measures the level of compliance with all measures for all patients.

The care bundle data collection tool is a way of sampling whether optimum care is being delivered by applying the bundle to a sample of patients. This approach is therefore very different from traditional auditing approaches that are designed to identify whether individual measures are being implemented.

1.2. What makes up a care bundle?

- 4-5 measures
- All or nothing compliance
- Measurement done by a non-clinician if possible
- Spread over patient's journey
- Evidence based
- Creates teamwork and communication
- Multiple functions of care essential for desired outcome

1.2.1. How should a care bundle be used in practice?

A care bundle is a quality improvement tool which can be used in general practice to identify both where care is in line with best practice and where improvements are needed. Some are disease specific and some are medication specific. The latter may also be known as patient safety bundles if they relate to high risk medication.

Bringing about changes in practice is not easy. To be an effective tool the results of the care bundle measurements must be discussed by ALL members of the team involved in the care of the patient. The practice team then need to take ownership of the issues identified and commit to changing the way care is provided, using tools such as the 'Plan, Do, Study, Act (PDSA) cycle.

Principles of successful measurement:

- The support of all members of the practice team should be obtained
- Data should be collected anonymously
- The results should be discussed by every member of the team
- The results should be used to plan and implement improvement initiatives
- Clinician support may be needed initially by the data collector until they are familiar with the measures.

1.3. Records

The care bundle is not a performance tool and so there is no requirement to report the measures achieved. The practice should keep a reflective log of improvements.

1.4. Resources

This care bundle has the following supporting resources:

- A word document data collection form
- An excel spreadsheet data collection form with a graphing function
- A reflective log template

Further information on Care Bundles and Improvement Models can be found at www.healthcareimprovementscotland.org/pspc.aspx

Further advice can be obtained from the Medicines Optimisation team, and specific queries about this care bundle can be directed to the author (details are on the front page).

2. Adult patients prescribed benzodiazepines or Z drugs

2.1. Search Criteria

Please identify a random sample of up to 20 adult patients a month in your practice prescribed a benzodiazepine or Z drug* on repeat prescription and/or regular acute. Use the data collection form to record the answer to each measure and transfer this to the spreadsheet. This should be repeated over a period of time, and the results discussed by the clinical team at regular intervals. Use of the spreadsheet will enable changes in practice to be monitored and compliance with the care bundle to be measured.

***Benzodiazepine and Z drugs** -

Diazepam	Nitrazepam
Buspirone	Oxazepam
Chlordiazepoxide	Temazepam
Clonazepam	Zaleplon
Loprazolam	Zolpidem
Lorazepam	Zopiclone
Lormetazepam	

2.2. Measures

01

Measure	**Has the patient tried non-pharmacological measures before drug therapy?**
Rationale	Before receiving a prescription (either new or repeat) for a benzodiazepine, patients should be given advice about non-drug therapies for anxiety or insomnia. Low-intensity non-pharmacological interventions should be offered to people with milder symptoms and high-intensity interventions for people with marked anxiety/functional impairment who have not responded to low-intensity interventions.

	Non-drug treatments for managing anxiety include: • Behaviour therapy — this may require referral to a counselling service, psychologist, or local mental health team • Relaxation techniques (such as progressive muscular relaxation and controlled breathing techniques) • More specialized psychological interventions (such as cognitive behavioural therapy) • Exercise (tailored to the person's capabilities) and other techniques (such as yoga and meditation) • Complementary or alternative therapies (such as aromatherapy, massage, and reflexology)
Source	Insomnia: NICE CKS: http://cks.nice.org.uk/insomnia Generalised anxiety disorder: NICE CKS: http://cks.nice.org.uk/generalized-anxiety-disorder Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults (partial update); NICE Clinical Guideline 113 (January 2011). http://www.nice.org.uk/Guidance/CG113

02

Measure	**Has the medication been prescribed for less than 4 weeks?**
Rationale	These drugs are indicated in the lowest possible dose for the shortest possible time in the acutely distressed As anxiolytics: • Benzodiazepines are indicated for the short-term relief (two to four weeks only) of anxiety that is severe, disabling or subjecting the individual to unacceptable distress, occurring alone or in association with insomnia or short-term psychosomatic, organic or psychotic illness. • The use of benzodiazepines to treat short-term "mild" anxiety is inappropriate and unsuitable. As hypnotics: Benzodiazepines should be used to treat insomnia only when it is severe, disabling, or subjecting the individual to extreme distress.
Source	British National Formulary July 2016. https://www.medicinescomplete.com/mc/bnf/current/ Committee on Safety in Medicines (CSM) Current Problems 21, Jan 1988 and CMO update 37, 2004. http://webarchive.nationalarchives.gov.uk/20150122075153/http://mhra.gov.uk/home/idcplg?IdcService=SS_GET_PAGE&ssDocName=CON2024486

03

Measure	**Has the patient been prescribed a dose within the BNF therapeutic range?**
Rationale	The effects (and therefore adverse effects) of specific benzodiazepines are dependent upon the dose administered and the pharmacokinetic profile. Factors potentially associated with an increased risk of developing dependency include long-term use, short duration of action, high dose, and high potency.
Source	British National Formulary July 2016. https://www.medicinescomplete.com/mc/bnf/current/ MeReC Bulletin Volume 15 number 5 April 2005: Benzodiazepines and newer hypnotics. http://filesdown.esecure.co.uk/NorthLancsPCT/MeRec_Bull_15_5_.pdf_07012011-1137-24.pdf

04

Measure	**Has the patient been given information about the risks & benefits of treatment, including co-prescription of drugs that increase the risk of the adverse effects?**
Rationale	Records should show that the patient has been given appropriate advice about the risks of benzodiazepine use, including the potential for dependence and tolerance. If the patient is aged 65 years or over, they or their carer have been given advice about the risks of benzodiazepine use in elderly patients. Studies have shown that in people who continue to take benzodiazepines long-term, there is: • An increased risk of fractured hips in older people, especially when they are on other medicines that increase the effect of benzodiazepines. • Impairment of mental function and memory in older people. This has sometimes been wrongly diagnosed as dementia. • An increased risk of injury in car crashes (due to the effect on alertness)
Source	Shaw E, Baker R (2005). Audit protocol: benzodiazepine prescribing in primary care. Leicester: Clinical Governance Research & Development Unit, Department of General Practice & Primary Health Care. Leicester. University of Leicester. https://www.researchgate.net/publication/289691058_Audit_protocol_Benzodiazepine_prescribing_in_primary_care Committee on Safety in Medicines (CSM) Current Problems 21, Jan 1988 and CMO update 37, 2004. http://webarchive.nationalarchives.gov.uk/20150122075153/http://mhra.gov.uk/home/idcplg?IdcService=SS_GET_PAGE&ssDocName=CON2024486 Ashton, H.C. (2011) The Ashton manual supplement. A supplement to Benzodiazepines: how they work & how to withdraw (2002). The Ashton Manual., University of Newcastle. www.benzo.org.uk

05

Measure	Has the patient been given the opportunity to withdraw/stop?
Rationale	The evidence suggests that benzodiazepines are no longer effective after a few weeks or months of regular use because of the development of tolerance. It is suggested that chronic users (four to eight weeks or longer) should be identified through a structured programme and, where appropriate, encouraged to gradually withdraw. The Mental Health National Service Framework in 1999 called upon health authorities to implement systems for monitoring and reviewing prescribing of benzodiazepines within local clinical audit programmes. Long-term use of benzodiazepines can give rise to many unwanted effects, including poor memory and cognition, emotional blunting, depression, increasing anxiety, physical symptoms and dependence and well as socio-economic costs. Withdrawal of a benzodiazepine should be gradual because **abrupt** withdrawal may produce confusion, toxic psychosis, convulsions, or a condition resembling delirium tremens Patients experiencing a current crisis or who have an illness for which the drug is required at the current time may be unsuitable for withdrawal. Referral to specialist teams may be appropriate for some patients, e.g., if the patient has a history of alcohol or other drug misuse or dependence; concurrent, severe medical or psychiatric disorder or personality disorder; or history of drug withdrawal seizures.
Source	National Service Framework: Mental Health. September 1999. https://www.gov.uk/government/publications/quality-standards-for-mental-health-services Benzodiazepine and z-drug withdrawal, NICE CKS, March 2009 http://cks.nice.org.uk/benzodiazepine-and-z-drug-withdrawal Shaw E, Baker R (2005). Audit protocol: benzodiazepine prescribing in primary care. Leicester: Clinical Governance Research & Development Unit, Department of General Practice & Primary Health Care. Leicester. University of Leicester. https://www.researchgate.net/publication/289691058_Audit_protocol_Benzodiazepine_prescribing_in_primary_care Ashton, H.C. (2011) The Ashton manual supplement. A supplement to Benzodiazepines: how they work & how to withdraw (2002). The Ashton Manual., University of Newcastle. www.benzo.org.uk Cormack MA, Sweeney KG, Hughes-Jones H, et al. Evaluation of an easy, cost-effective strategy for cutting benzodiazepine use in general practice. Br J Gen Pract 1994;44:5-8 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1238754/pdf/brjgenprac00036-0009.pdf

Appendix One: Abbreviations

Abbreviation	Definitions
NICE	National Institute for Health and Care Excellence
SPC	Summary of Product Characteristics
NICE CG	NICE Clinical Guideline
NICE QS	NICE Quality Statement
BNF	British National Formulary