SUMMER 2019

A publication of
Alzheimer's Queensland.

Dementia Matters

In this edition...

Alzheimer's
QUEENSLAND

Alzheimer's Queensland

Alzheimer's Queensland is Queensland's largest not-for-profit community organisation whose primary aim is to maintain the quality of life of people with dementia and their caregivers. We support the desire of most people to remain living in their own home as long as possible and assist families and caregivers to facilitate this.

We aim to do this by offering the following:

Statewide Information, Education and Support Services:

- 24 hour 7 days per week professionally staffed Advice Line (ph: 1800 639 331)
- Community education
- Library resources
- Interactive website at www.alzheimersonline.org
- Professional education
- Family carer education
- Support groups – face to face and telephone support groups
- Individualised support
- Fact sheets and specific information requests posted as required
- Dementia Matters newsletter

Alzheimer's Queensland

47 Tryon Street
Upper Mt Gravatt Qld 4122
Telephone: (07) 3422 3000
Fax: (07) 3343 2557
Email: helpline@alzheimersonline.org
Website: www.alzheimersonline.org
Dementia Advice line: 1800 639 331

A Good News Story Christine's Journey

The NDIS (National Disability Insurance Scheme) is the new way of providing individualised support for people with disability under 65yrs, their families and carers. Alzheimer's Queensland supports NDIS participants to achieve their chosen goals for a positive future.

Christine moved to Brisbane to live near her sister following the onset of memory issues. She chose to live independently in her own unit. Christine's interests are sketching, drawing, Rock n Roll dancing, going out and being social. To maintain these hobbies and interests, Christine attends our Centre three days a week and participates in social outings to parks, rock 'n' roll at a local club and live music events every Sunday.

Christine has a carer to promote independence and meet hygiene needs. As Christine's needs change her NDIS support plan will be reviewed with her to ensure reasonable and necessary support is always provided.

Current Medications and Research

Currently there is no cure for the decline in cognition, function and behaviour which is associated with Alzheimer's Disease. Majority of research is now focusing on the early detection of damage to the brain that may indicate a risk for future dementia. Changes to the brain may occur 10-20 years before the signs and symptoms of dementia appear. This research may eventually find ways of preventing or delaying the onset of dementia.

Currently there are two classes of medication to treat some of the symptoms of dementia cholinesterase inhibitors (ChEIs: donepezil, rivastigmine and galantamine) to improve the transmission of messages between nerve cells and the N-methyl-D-aspartate (NMDA) receptor antagonist, memantine to block the effects of glutamate which in excess contributes damaging brain cells.

In ceasing or slowly reducing these medication a decline may be noted. The medication may be resumed at a previous effective dose if it is considered beneficial to continue the treatment. Benefits of ceasing the medication may include reducing the number and administration time of medications particularly if the person is resistant to medication taking or having swallowing difficulty; reduced risk of side effects or drug interactions; reduced cost. Any medication changes are made with the informed consent of the person living with dementia or their substitute decision makers.

Choice of Medication

When prescribing medication people with or without dementia are assessed to ensure age, frailty, life expectancy, chronic illness (in particular liver and kidney disease), polypharmacy, over-the-counter medication, supplements and herbals, multiple prescribers, previous medical allergies and overall health, quality of life and goals are considered. This is to ensure the benefits of medication outweigh the risks. Benefits and risks can also change over time.

Being over the age of 80yrs having multiple doctors prescribing (during hospital admissions, specialist reviews, a change in GP), substance use and a history of not taking medications as prescribed can add to risks associated with medication.

Immunisation can reduce the risk of pneumonia, influenza, shingles and mortality and should be encouraged unless contraindicated e.g. previous allergic reaction or if immunocompromised.

In an effort to address a perceived failure of conventional medicine and to enhance health, carers and the person living with dementia may want to use herbal medicines, naturopathy, and other traditional and complementary medicines. This should be done in collaboration with conventional treatments to reduce the risks associated with products that are not research based, potential adverse effects or interactions with other medication and the potential for unqualified practitioners giving misleading information.

Polypharmacy

Polypharmacy is taking more than 4 or more drugs (over-the-counter, prescription and/or traditional medications). 2 out of 3 Australians over 75yrs take 5 or more medicines. The clinical consequence of adverse drug reactions may include falls, confusion, frailty, loss of independence, reduced quality of life, hospitalisation and even death. Polypharmacy also increases the risk of delirium for an ageing person with or without dementia. Polypharmacy often accompanies chronic health issues which require medications e.g. arthritis, cardiac issues, diabetes, thyroid function changes or vitamin deficiencies, depression, osteoporosis, respiratory or kidney disease.

To start low, go slow and regularly review medications and the dose is strongly recommended when prescribing dosages for older people. Medication may be ceased due to side effects, lack of benefit, terminal illness or extreme frailty occurs.

Polypharmacy is an important predictor of the risk of harm. When visiting doctors or hospitals all medication and medication delivery aids should be taken with you and discussed. The patient or client should be actively involved in decision-making with an awareness of side effects and administration details including date of review.

Awareness of similar sounding names for medications or the same drug having a different name will reduce the risk of harm associated with medication. Unwanted or stockpiled medication should be returned to a pharmacy for disposal to minimise harm from medication.

Withdrawing medication

Deprescribing (withdrawing) medication may be considered following thorough medical assessment and planning. For people living at home or in residential care a medication review with referral by your GP to an accredited pharmacist can potentially lead to deprescribing or the use of an alternative medication. Seeking a specialist opinion from a geriatrician, neurologist or psychiatrist can support the process. The person and their carers have the right to ask if safer treatment options exist, what the benefits and risks are (including cost) and what the disadvantages are for not taking the medication.

Preventive medications may be withdrawn by a doctor in consultation with the substitute decision-maker in the later stages of dementia where benefits may no longer warrant their use e.g. medication for osteoporosis, statins commenced due to history of coronary artery disease, stroke, and diabetes mellitus. Medication e.g. antibiotics or analgesics could be continued if contributing to comfort and quality of life.

Altering Medication

One in five older patients may have difficulty swallowing medications. Swallowing difficulty, polypharmacy, limited availability of different forms such as in liquid, patch, wafer or suppository form may lead to medication being inappropriately crushed, dissolved or disguised in food or liquids. Modifying the medication should be done only with the Doctor's knowledge and when following the product information and guidelines.

Speech pathologists may be able to improve swallowing safety and efficiency, medication lubricants or alternative medication in another dosage form may be trialed to ensure the medication has the intended effect.

Vascular Dementia

Vascular dementia is the second most common cause of dementia. Disease effecting the heart or blood vessels may require medication as part of the treatment e.g. anticoagulants used for atrial fibrillation can assist in reducing the risk of dementia.

Other vascular risk factors such as hypertension, high cholesterol and diabetes may also require medication. Lifestyle change will also reduce risk e.g. exercise, Mediterranean diet, not smoking and reducing alcohol.

Delirium

Other medications may focus on the treatment of an acute, reversible cause of delirium such as infection, constipation, pain. The risk of delirium increases by 5 times for the person with dementia.

Delirium can present on a spectrum from lethargy and withdrawal to severe agitation and result in further cognitive decline if not identified and treated. Whether at a hospital or seeking a GP assessment of delirium, it is essential to have family or substitute decision makers as historians in relation to the current changes or issues of concern. Baseline information in relation to the person's usual cognition, behaviour, function and current medication is important for an accurate diagnosis.

Informed consent by the person with dementia is not always possible. Their decision-making capacity may reduce or fluctuate but they do have a right to participate in decision-making whenever possible.

The risk of delirium increases in hospital particularly if over 65yrs, a person with dementia, a severe illness or a hip fracture.

The risk of harm from medication may increase in hospital when patients are transferred to a different area such as a ward, emergency room, intensive care unit or to a nursing home or during a change of shift or visits to GPs and different specialists. These situations increase the potential for medication errors when good communication and processes of handover are not in place and when carers are also not fully informed.

Behaviours and Unmet Needs

Behavioural changes which may accompany dementia and/or delirium require the use of behavioural strategies with input from health team professionals with dementia expertise working with carers (formal and informal) and the person living with dementia. Strategies are based on a comprehensive assessment of physical, social, cognitive and psychological needs of both the person with dementia and their carer. Strategies aim to address potentially reversible risk factors or triggers related to hydration, nutrition, sleep and rest and fear, boredom, anxiety and distress.

Wellbeing can be enhanced through safe mobilisation, exercise, toileting and self-care, avoiding restraints, reducing noise, wearing hearing aids, spectacles and dentures, reorienting, acknowledging feelings, reassuring with genuine regard and simple statements, redirecting and being aware of valued routines and rituals. Music, dance, massage, familiar items, environments, voices and people are sensory supports which may be useful. Effective behavioural strategies should reduce the risks of agitation, aggression, falls, fractures, infection and higher mortality associated with delirium and/or dementia.

Behaviour Change and Medication

Psychotropic and sedative-hypnotic medications for hallucinations, delusions or severe agitation and aggression may be considered if severe distress or risk of harm to self or others is occurring and behavioural (non-pharmacological) interventions have not been successful. Antipsychotic medications may later be withdrawn without behaviours deteriorating. Regular medication reviews are recommended with the potential to reduce doses or eliminate psychoactive medications e.g. anticholinergics, sedative-hypnotics, opioids which are being administered regularly or on an as needed basis. Antipsychotic medication is unlikely to address issues such as wandering, undressing, inappropriate voiding, verbal aggression or screaming.

Risperidone is the only approved PBS drug for the treatment of Behavioural and Psychological Symptoms of Alzheimer's Disease. Side effects include cerebrovascular events (including stroke) with an increased risk if the person already has risk factors such as high blood pressure, diabetes or history of strokes.

The antipsychotic haloperidol has a tendency to cause side effects such as tremor, slurred speech, anxiety, restlessness, pacing, gait changes or repetitive facial movements in particular for people with Lewy Body Dementia.

Benzodiazepines e.g. Valium are addictive and preferably used only short term. They potentially assist sleep or reduce anxiety and agitation but may increase the risk of fall, pneumonia and death with the risk increasing with higher doses and longer treatments.

Depression

Depression may follow a diagnosis or precede a dementia diagnosis when the person is aware that their function or memory is changing. Some people may have a long history of depression. Severe depression should be treated with antidepressants. Mild depression may respond to slowly introducing behavioural strategies such as social and cognitive engagement, healthy lifestyles including exercise, limiting alcohol and drugs. Cognitive Behaviour Therapy may also be trialed. Deep-breathing exercises, muscle relaxation or yoga may assist.

Cancer

The risk of both dementia and cancer increases with age. Early detection of the signs and symptoms of cancer by carers may ensure early treatment occurs particularly when people living with dementia may not be good historians.

Medication to treat cancer can sometimes cause side effects e.g. difficulty with memory, concentration, multitasking. People should always discuss potential for and duration of side effects of medication and treatment with their treating doctor and pharmacist.

Incontinence

Incontinence is more common in older people, in females and in those living with dementia. it increases the risk of falls and early admission to residential aged care. Medications can contribute to urinary problems including incontinence and the cause is often incorrectly attributed to the progression of the dementia. In the event of a recent onset of incontinence, medication could be a potential cause and should be reviewed as part of a continence assessment. Some of the drugs from the following groups potentially may contribute to incontinence e.g. diuretics, sedatives, antipsychotics, antidepressants, anti-hypertensives, opioids among others.

Pin on your notice board

Alzheimer's Queensland Services and Contacts

www.alzheimersonline.org

Dementia Advice Line

1800 639 331

Open 24 hours a day, 7 days a week.

Free call from landline and public phones.

Or email: helpline@alzheimersonline.org

For information and emotional support for people with dementia, families, friends and staff. The Advice Line has a database of services in Queensland to provide information and referrals.
Call for free information
e.g. fact sheets or brochures to be mailed out.

AQ Rehab

In home - Physiotherapy
Occupational Therapy
Speech Therapy

1800 180 023

Care Services

Brisbane North, Brisbane South, Ipswich, Toowoomba

Seven days per week including:

- Personal Care; Domestic Assistance
- Social Support; Transport
- Allied Health Assessments
- Respite - Centre-based – day, overnight or emergency
- Respite for Working Carers
- Home Maintenance

Multi-Service Respite Centres located at:

- Gordon Park; Mt Gravatt; Ipswich; Toowoomba

Residential Aged Care located at:

- Garden City Aged Care Services, Upper Mt Gravatt
- Rosalie Nursing Home
- Windsor Aged Care Services

Home Care Packages at:

- Brisbane South
- Logan River
- Brisbane North
- West Moreton
- Darling Downs
- Gold Coast

Call the Advice Line for vacancies for Home Care Packages and for Residential Aged Care both permanent and respite.

Carer Support Groups - 2019

Provide information and support for those caring for a friend or family member with dementia.
Please phone 1800 639 331 for more information, to register or to be placed/removed on the mailing list.

- **Toowoomba:** First Monday of month: 9:30am – 11:30am Park Motel, 88 Margaret Street Toowoomba 1 April, 13 May, 3 June, 1 July.
- **Toowoomba Men Only:** 11:30am -13:30pm (Includes Lunch) For Venue and Dates please contact 07 4635 2966
- **Ipswich:** Third Wednesday of every month: 10:00am – 12 noon. Cottage 85 Chermside Road, Ipswich 20 March, (17 April evening) 22 May, 19 June, 17 July.
- **Ipswich Evening:** Evening 5pm – 7pm 17 April.
- **Windsor:** First Thursday of month: 10:00am – 12 noon. Windsor Aged Care Services 26 Palmer Street, Windsor (Enter via Reception) 4 April, 2 May, 6 June, 4 July.
- **Redcliffe:** First Thursday of month: 2:00pm – 4:00pm Redcliffe Cultural Centre, Terry Walker Room, Downs Street Redcliffe. 4 April. 2 May, 6 June, 4 July.
- **Mt Gravatt:** First Friday of month: 10:00am – 12 noon. 47 Tryon Street, Upper Mt Gravatt. 5 April, 3 May, 7 June, 5 July.
- **Mt Gravatt Chat Group (Partners attend) :** 2nd Wednesday of month: 10:00 - 12noon. The Village Coffee Club 32/1932 Logan Rd, Upper Mt Gravatt. 13 March, 10 April, 8 May, 12 June, 10 July.
- **Garden City Evening:** 52 Khandalla Street, Upper Mount Gravatt 6:00pm – 7:00pm. 15 May.
- **Gordon Park Evening:** 45 Shamrock Street, Gordon Park 6:00pm – 7:30pm. 16 May.
- **Qld-wide Telephone Support Group:** Last Wednesday of every month: 1:00pm – 2:00pm. AAQ organises telephone link-up at no cost to members. 27 March, 24 April, 29 May, 26 June, 31 July.

For further details or to register please contact
the Alzheimer's Queensland Dementia Advice Line 1800 639 331

Alzheimer's
QUEENSLAND