MONASH University

CLINICAL PRACTICE GUIDELINES FOR THE APPROPRIATE USE OF PSYCHOTROPIC MEDICATIONS IN PEOPLE LIVING WITH DEMENTIA AND IN RESIDENTIAL AGED CARE

A companion guide for people living with dementia, their carers and families

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BACKGROUND

About this Companion Guide

This is a Companion Guide, written in simpler language, for the recently published Clinical Practice Guidelines for the Appropriate Use of Psychotropic Medications in People Living with Dementia and in Residential Aged Care.

The recommendations in the Guidelines are based on the best research evidence related to the use of psychotropic medications (medications that affect behaviour, mood, thoughts, or perception including antipsychotics, benzodiazepines and antidepressants) for managing so-called 'changed behaviours' often experienced by people living with dementia.

The Guidelines are based on research evidence and views of experts including people impacted by dementia.

Changed behaviours can be managed with or without medications or by using a combination of both approaches. Ideally medications should only be used after trying other approaches, such as modifying the environment, or addressing any physical or mental health problems the person may be experiencing. For this reason, this Companion Guide should be read in conjunction with other resources on non-medication strategies for managing changed behaviours.

Note that the Guidelines do not cover the use of psychotropic medications for people living with mental illness (e.g. schizophrenia, bipolar disorder) or for people receiving end-of-life care and people receiving palliative care.

Who is this Companion Guide for?

This Companion Guide is for anyone who is impacted by dementia. This includes people living with all types of dementia, their carers and families. The Companion Guide is also for the wider public. Health and care professionals may find the Companion Guide useful for shared decision-making.

What are changed behaviours?

The term 'changed behaviours' is used to describe what clinicians sometimes refer to as behavioural and psychological symptoms of dementia (BPSD). There are many reasons why a person with dementia's behaviour may change in ways that are distressing for them and those around them. Changed behaviours may reflect needs or sensations including frustration, pain, boredom and loneliness.

GENERAL PRINCIPLES

How to decide whether or not to use psychotropic medications for changed behaviours?

Prescribers, pharmacists, aged care providers, nursing and aged care staff all have responsibilities to actively involve you in deciding whether or not you should take psychotropic medications. Your physical, emotional and spiritual needs should always be considered alongside the need for medications.

Your ability to make decisions about medications may change over time and may be better or worse some days. However, it should not be assumed that you cannot make decisions regarding your own treatment. A trusted person may assist you to make decisions. This is called supported decision-making. Supported decision-making enables you to make decision about your own health care with assistance.

If you lose your ability to make decisions on your own, you may benefit from a substitute decision-maker to make decisions for you.

SUBSTITUTE DECISION-MAKER

Substitute decision-making is legislated by Australian states and territories. In some Australian jurisdictions there are occasions when a substitute decision-maker cannot make health decisions on behalf of a person living with dementia and health decisions must be referred to the relevant Tribunal.

If you are experiencing distressing changes in behaviour it is not always appropriate to use medications. Other approaches should be used first. This might include modifying the environment, or addressing any physical or mental health problems you may be experiencing.

Deciding to use a psychotropic medication

You and/or your substitute decision-maker should be involved in a comprehensive discussion about possible benefits and harms any prescribed psychotropic medication. This discussion should occur in a way that you are able to understand. Your treatment preferences should be documented and reassessed regularly.

In addition, you and/or your substitute decision-maker should give informed consent and this should be documented. If a substitute decision-maker provides informed consent, the possible benefits and harms should still be explained to you as far as possible. The care team should explain the specific symptoms that the psychotropic medication may improve. These are called target symptoms and they should be identified, measured and documented. The date that the medication will be reviewed should be discussed with you and/or your substitute decision-maker, nurse and aged care staff.

How and when should psychotropic medications be reviewed?

Psychotropic medications should be reviewed regularly. Your care team might request a review if the medication does not seem to be helping you, if your goals of care change, or if you have side effects. You and/or your substitute decision-maker can also request a review at any time.

How should psychotropic medications be discontinued?

If it is decided, for whatever reason, that you should stop taking a prescribed psychotropic medication, you and/or your substitute decision-maker should be involved in a comprehensive discussion about how to do this and the possible benefits and harms. Stopping a psychotropic medication should occur slowly to minimise the risk of your symptoms returning.

You and/or your substitute decision-maker should be involved in developing the discontinuation plan. You may have previously attempted to stop a medication. If so, the discontinuation plan should consider the lessons learned from these previous attempts. If you decide to discontinue, you should be reassured that the psychotropic medication can be restarted again if necessary. The discontinuation plan should be available to you and/or your substitute decision-maker in addition to your health and care professionals.

How should your aged care home monitor psychotropic medication use?

Your aged care home should have a Medication Advisory Committee that meets at least four times per year to review the overall use of psychotropic medications in the home. The Medication Advisory Committee will also develop, implement and evaluate activities to ensure that psychotropic medications are used appropriately.

Making complaints

The process for making complaints about medication prescribing, dispensing, administration or monitoring should be explained to you and/or your substitute decision-maker, your carers and family.

Involving carers

Your carers should be considered partners in medication management as they often possess unique knowledge about you and the medications that you use.

Advance care planning

You are encouraged to undertake advance care planning and have an advance care directive. This advance care directive may include your preferences and values related to prescribing and administration of psychotropic medications. Your care team should recognise these preferences and values.

ANTIPSYCHOTICS

In this section you will find information for a class of psychotropic medications known as antipsychotics. There are two main types of antipsychotics – first-generation (typical) and second-generation (atypical) antipsychotics. Risperidone is an example of a second-generation antipsychotic.

When is it appropriate for people living with dementia to use antipsychotics?

In a limited number of circumstances, short-term use of risperidone may be considered for people living with some, but not all, types of dementia who are experiencing:

- Distressing symptoms of psychosis. This can include sensing things that are not really there (hallucinations) and having beliefs that are not based on reality (delusions) or
- Severe agitation or aggression that is a direct threat to themselves or those around them.

For people with dementia who experience calling out or crying out, wandering or disinhibition (e.g. behaviours that may seem inappropriate or rude to others), antipsychotics should not be prescribed because they are of no benefit for these behaviours.

RECOMMENDATION

First-generation antipsychotics are not recommended for people living with dementia and changed behaviours as the risk of harms outweigh the potential benefits.

RECOMMENDATION

Routine initiation of second-generation antipsychotics is not recommended for people living with dementia and changed behaviours as the risk of harms outweigh the potential benefits.

RECOMMENDATION

If a person living with dementia is showing distressing psychotic symptoms and/or aggression/agitation that is a direct threat to themselves or others, short-term use of risperidone may be considered. Before starting risperidone, your prescriber should consider your individual harms and benefits. Your care team should document your specific target symptoms when initiating risperidone.

Potential adverse events of antipsychotics

- cardiovascular events (e.g. heart attack)
- stroke
- falls and fractures
- sedation (e.g. drowsiness, sleepiness)
- constipation
- difficulty emptying your bladder
- dry mouth
- problems with memory or concentration
- swollen ankles, feet and legs
- increase in blood sugar levels and weight gain
- inability to sit still, stiff muscles, shaking
- low blood pressure (sudden drop in blood pressure when you stand up from sitting or lying down) and dizziness
- abnormal heart rhythm
- death

If you use an antipsychotic, there should be a plan in place for monitoring possible adverse events. This plan should be available to you and/or your substitute decision-maker, prescribers, pharmacists, nurses and aged care staff as applicable. The plan should outline who is responsible, their specific roles and responsibilities, when monitoring will take place and what steps should be taken if a serious adverse event occurs.

RECOMMENDATION

Your care team should review the harms and benefits of continuing an antipsychotic for changed behaviours with you and/or your substitute decision-maker and discuss the option of discontinuation.

Antipsychotic use in people with dementia with Lewy Bodies

Antipsychotics should be avoided in people with dementia with Lewy bodies due to the high risk of adverse events. Acetylcholinesterase inhibitors are a class of medication that may be considered as an alternative. If an antipsychotic is used, a second-generation antipsychotic with a lower risk of specific adverse events should be considered. Your care team should conduct frequent monitoring for adverse events. The lowest effective dose for the shortest possible duration should be used.

Before starting an antipsychotic

The prescriber of the antipsychotic should consider the possible harms and benefits for you. This should include your risk of cardiovascular events (e.g. heart attack), stroke, and falls and fractures.

In addition, your current medications should be reviewed to assess whether a new medication might interact with any other medications you are taking.

The harms and benefits for you taking an antipsychotic should be discussed with you and/or your substitute decision-maker as appropriate. The discussion should include talking about your treatment preferences and should be understandable to you. This discussion should be in your preferred language where possible.

Health and care professionals should discuss their decision to prescribe, dispense and administer an antipsychotic to you for the first time with at least one other healthcare professional directly involved in caring for you. You can ask if this has happened if you are not sure.

If you choose to start an antipsychotic for changed behaviours

If you start an antipsychotic, it should be at a low dose and the dose should only be increased if needed. Your care team should review whether the medication is working every 1-2 weeks and the date of next review should be planned and documented.

You should not generally use an antipsychotic for more than 12 weeks unless it is a period of dose tapering as part of planned treatment reduction or discontinuation.

Continuation beyond 12 weeks should only occur if there has been:

- a review by a psychiatrist or geriatrician; or
- a formal documented discussion between the prescriber and a psychiatrist or geriatrician in which both practitioners agree; or
- clinical review involving the prescriber and at least one other medical practitioner in which both practitioners agree.

When should antipsychotics be discontinued?

Your prescriber should consider discontinuing your antipsychotic treatment no later than 12 weeks after it was started if:

- you have not experienced a documented improvement in the symptoms for which it was prescribed; or
- your treated symptoms have improved or appear stable; or
- you experience an adverse event; or
- you were not prescribed the antipsychotic for an appropriate reason.

How should antipsychotics be discontinued?

If a decision is made to stop an antipsychotic, your care team should create a discontinuation plan for you.

Slow tapering (slowly reducing the dose until you have stopped using the antipsychotic completely) may reduce the risk of your symptoms coming back. This will also reduce the risk of side-effects associated with stopping the medication too quickly (discontinuation symptoms).

Your antipsychotic should be tapered more slowly if you have:

- experienced severe distressing psychosis and severe aggression/agitation; or
- been using higher doses; or
- been prescribed an antipsychotic for longer than 12 weeks.

Sometimes after discontinuing an antipsychotic, your symptoms may come back. This is known as recurrence of symptoms. These recurrent symptoms should be measured and documented by your care team. If these recurrent symptoms cannot be managed using non-medication strategies, your care team could consider restarting you on an antipsychotic or trialling a different medication. This should be discussed with you and/or your substitute decision-maker.

Other reasons for continuing antipsychotics

If you are living with a mental illness (e.g. schizophrenia, bipolar disorder) and you develop dementia, your antipsychotic may be continued according to your treatment plan that has been developed in consultation with your psychiatrist. Regular review of the harms and benefits of the antipsychotic should be undertaken by, or in consultation, with a psychiatrist.

BENZODIAZEPINES

In this section you will find information for a class of psychotropic medications known as benzodiazepines. Examples of benzodiazepines include temazepam, diazepam and oxazepam.

When is it appropriate for people living with dementia to use benzodiazepines?

If you are experiencing sleep difficulties such as difficulty falling or staying asleep, it is always important to investigate the underlying causes of these difficulties. You should try non-medication strategies for managing your sleep first. If these non-medication strategies alone are unsuccessful, benzodiazepines may be helpful for you in the short term.

Potential adverse events of benzodiazepines

- excess sedation
- daytime sleepiness and drowsiness
- central nervous system depression (e.g. slow brain activity)
- respiratory depression (e.g. slow breathing)
- problems with memory or concentration
- falls and fractures
- tolerance and dependence (e.g. the body 'gets used' to the medication over time, so higher doses are required to produce the same effect)

If you use a benzodiazepine, there should be a plan in place for monitoring possible adverse events. This plan should be available to you and/or your substitute decision-maker, prescribers, pharmacists, nurses and aged care staff as applicable. The plan should outline who is responsible, their specific roles and responsibilities, when monitoring will take place and what steps should be taken if a serious adverse event occurs.

RECOMMENDATION

Routine use of benzodiazepines is not recommended for sleep disturbances for people living with dementia and changed behaviours. Special considerations may apply to benzodiazepine use for conditions including but not limited to significant alcohol withdrawal, acute seizures and end-of-life care in the last days of life.

RECOMMENDATION

You and/or your substitute decision-maker should be involved in a review of the harms and benefits of continuing a benzodiazepine. If you recently started using a benzodiazepine for sleep disturbance, discontinuation should be considered after a maximum of 2 weeks. If you have been using a benzodiazepine on a long-term basis for sleep disturbance, you and/or your substitute decision-maker should be involved in a discussion about the option of discontinuation.

Before starting a benzodiazepine

The prescriber of the benzodiazepine should consider the possible harms and benefits for you. This should include your risk of excess sedation, central nervous system depression (e.g. slow brain activity), respiratory depression (e.g. slow breathing) and falls.

The harms and benefits for you of taking a benzodiazepine should be discussed with you and/or your substitute decision-maker as appropriate. The discussion should include talking about your treatment preferences and should be understandable to you. This discussion should be in your preferred language where possible.

If you choose to start a benzodiazepine for sleep difficulties

If you choose to take a benzodiazepine it should generally be:

- Short-acting and be a type of benzodiazepine that does not have active metabolites (substance produced when the body processes the medication); and
- Used at the lowest effective dose and for the shortest possible duration.

You can ask your prescriber or pharmacist if the benzodiazepine that has been prescribed for you is short-acting and without active metabolites.

When should benzodiazepines be discontinued?

You should not generally take a benzodiazepine for sleep difficulties for more than 2 weeks.

You and/or your substitute decision-maker should be involved in discussions with your care team about when your benzodiazepine should be discontinued. The end-date should be planned and documented by the care team when the benzodiazepine is first prescribed.

How should benzodiazepines be discontinued?

If a decision is made to stop a benzodiazepine, your care team should create a discontinuation plan for you.

Slow tapering (slowly reducing the dose until you have stopped using the benzodiazepine completely) may reduce the risk of your symptoms coming back. This will also reduce the risk of side-effects associated with stopping the medication too quickly (discontinuation symptoms). Your care team should monitor you regularly and the dose of your benzodiazepine can be adjusted to help reduce discontinuation symptoms.

If your sleep difficulties return after you have stopped taking the benzodiazepine then your care team should record how severe these difficulties are for you.

If these recurrent sleep difficulties cannot be managed using non-medication strategies, your care team could consider restarting or maintaining the current dose for 1-2 weeks, then continuing to taper the benzodiazepine. This should be discussed with you and/or your substitute decision-maker.

ANTIDEPRESSANTS

In this section you will find information for a class of psychotropic medications known as antidepressants. Some classes of antidepressants include selective serotonin reuptake inhibitors (e.g. citalopram, sertraline), tricyclic antidepressants (e.g. amitriptyline) and tetracyclic antidepressants (e.g. mirtazapine).

When is it appropriate for people living with dementia to use antidepressants?

When an adequate trial of non-medication strategies alone has been unsuccessful, it is appropriate to consider an antidepressant when a doctor has diagnosed you with moderate major depressive disorder and you have previously responded to an antidepressant.

It is also appropriate to consider an antidepressant alongside non-medication strategies when a doctor has diagnosed you with severe major depressive disorder or if you have a depressive disorder with suicidal ideation and/or risk of self-harm.

When are antidepressants not recommended for people living with dementia?

Antidepressants are not routinely recommended for treating agitation, sleep difficulties or new depressive symptoms. Antidepressants are also not routinely recommended if your doctor has diagnosed you with mild-to-moderate major depressive disorder.

You should generally avoid antidepressants with strong anticholinergic side-effects (e.g. tricyclic antidepressants). You can ask your prescriber or pharmacist if the antidepressant that has been prescribed for you has anticholinergic properties. It is also recommended that you avoid using different types of antidepressants at the same time.

RECOMMENDATION

If you have been using an antidepressant for mild-to-moderate major depressive disorder, it is recommended that the harms and benefits of continuation are regularly reviewed and the option of discontinuation be discussed.

If you experience a first-time episode of severe major depressive disorder and respond to treatment, your antidepressant should be continued for six months after symptoms have resolved then a trial of discontinuation should be considered.

If you develop severe major depressive disorder, and you have had one or more previous episodes of severe major depressive disorder (or depressive disorder with suicidal ideation and/or risk of self-harm) you should consider continuing treatment and reviewing regularly for harms. This review should be undertaken by, or in consultation, with a psychiatrist, geriatrician and/or older person's mental health team.

Potential adverse events of antidepressants

- falls
- sleep difficulties (e.g. difficulty falling or staying asleep)
- fatigue
- problems with memory or concentration
- agitation
- low sodium levels in the blood
- abnormal heart rhythms
- bleeding
- diarrhoea or constipation
- nausea
- serotonin syndrome (due to accumulation of serotonin in the body; symptoms can be mild to severe e.g. diarrhoea, tremors, confusion, high fever, seizures)
- dry mouth, dry eyes and urinary retention (e.g. difficulty emptying your bladder)

If you use an antidepressant, there should be a plan in place for monitoring possible adverse events. This plan should be available to you and/or your substitute decision-maker, prescribers, pharmacists, nurses and aged care staff as applicable. The plan should outline who is responsible, their specific roles and responsibilities, when monitoring will take place and what steps should be taken if a serious adverse event occurs.

If you choose to start an antidepressant

If you choose to take an antidepressant for major depressive disorder, the class of antidepressants called selective serotonin reuptake inhibitors usually have a better safety profile than other classes of antidepressants. However, this class of antidepressants may still sometimes cause adverse events (e.g. sleep difficulties, falls, bleeding and low blood sodium levels).

When you start taking an antidepressant, you and/or your substitute decision-maker should be involved in a discussion about ensuring that you take them as directed, how long it might take medication to be effective, possible adverse events, and risk of experiencing side-effects if you stop taking it quickly.

For how long should people living with dementia use antidepressants?

Your care team should review how you are going with the antidepressant within 2-4 weeks of starting the medication. The full effects of the medication may not be seen for 4-6 weeks.

How long you take the medication will be specific to you. If the antidepressant is effective for you within 4-6 weeks, you may continue taking the same dose for 6 months and then have this reviewed. It may be appropriate for you to then stop taking the medication.

RECOMMENDATION

Antidepressant discontinuation should be considered if you are using an antidepressant for agitation and do not have major depressive disorder (or another appropriate indication for antidepressant use).

RECOMMENDATION

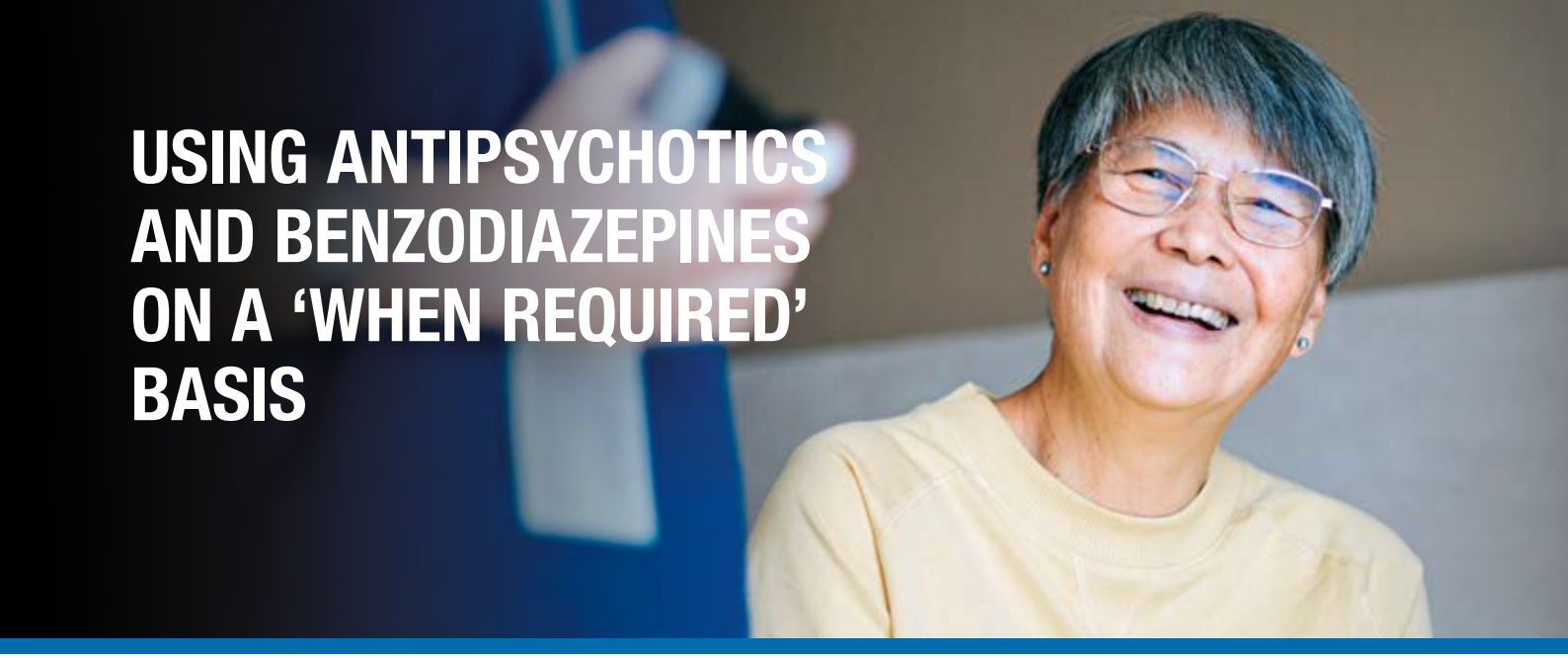
Routine use of antidepressants for treating agitation is not recommended due to the risk of adverse events and lack of evidence for effectiveness. However, if you have not responded to adequate non-medication strategies and a medication is being considered, a selective serotonin reuptake inhibitor may cause less adverse events than an antipsychotic. Citalopram has the strongest evidence for treating agitation.

How should antidepressants be discontinued?

Your care team should create a plan for you about how to stop taking the antidepressant you have been prescribed. Slow tapering (slowly reducing the dose until you have stopped using the antidepressant completely) may reduce the risk of your symptoms coming back. This will also reduce the risk of side-effects associated with stopping the medication too quickly (discontinuation symptoms). Discontinuation symptoms can last up to 6-8 weeks in people who have used an antidepressant for a long time.

Other reasons for continuing antidepressants

If you have been diagnosed with severe major depressive disorder or depressive disorder with suicidal ideation and/or risk of self-harm you should consider continuing your antidepressant and reviewing regularly for harms. These reviews should be undertaken by, or in consultation with, your psychiatrist, geriatrician and/or older person's mental health team.



USING ANTIPSYCHOTICS AND BENZODIAZEPINES ON A 'WHEN REQUIRED' BASIS

Sometimes antipsychotics or benzodiazepines are prescribed on what is known as a 'when required' basis. You may have heard this referred to as PRN ('pro re nata'). Using antipsychotics or benzodiazepines in this way is not necessarily safer than using them on a regular basis (e.g. daily).

What steps should occur if antipsychotics and benzodiazepines are used on a 'when required' basis?

Your prescribers should be trained to understand the needs and requirements of clinical supervision of PRN administration. Your nurses and aged care staff should be trained to recognise antipsychotic or benzodiazepine adverse events.

You and/or your substitute decision-maker should give informed consent. If it would be unsafe to delay prescription then consent should be obtained as soon as possible afterwards.

There should be an audit of the number of times a PRN antipsychotic or benzodiazepine is administered over the first month it is prescribed for you.

Clear records of each PRN administration of the medication should be available to those involved in prescribing, dispensing and administering medications. The outcome of the administration should be documented in the nursing notes.

RECOMMENDATION

It is recommended that people living with dementia and changed behaviours are not routinely prescribed antipsychotics or benzodiazepines on a PRN basis. PRN antipsychotic or benzodiazepine use may be acceptable as part of a 'step-down' or staged discontinuation of the medication. A PRN antipsychotic or benzodiazepine should only be prescribed for a specific target symptom and this should be documented in the medication chart, medical record, behaviour support plan and nursing progress notes where applicable. PRN benzodiazepine use could be considered for conditions such as significant alcohol withdrawal, acute seizures or end-of-life care in the last days of life.

IMPROVING MEDICATION USE AND APPROPRIATENESS IN RESIDENTIAL AGED CARE HOMES

There are a number of ways to help ensure that medications are used safely, effectively and appropriately in residential aged care homes. This includes regular medication reviews and ensuring staff are appropriately trained and educated.

Provision of comprehensive medication reviews

You should receive a comprehensive medication review of your medications within 3 months of moving to your aged care home. The report produced as part of this review should be made available to you and/or your substitute decision-maker. The report should be uploaded to your aged care provider organisation's electronic medical record system and to your My Health Record if applicable.

You and/or your substitute decision-maker should be involved in deciding which medication review recommendations are implemented. The outcomes of the medication review should be followed up within 3 months of the review being completed. Repeat medication reviews may be required if your medication-related problems have not been resolved, if your goals of care have changed, or if there are significant changes to your medications or medical conditions.

Medication Advisory Committees

Your aged care home should have a Medication Advisory Committee (MAC). A MAC is made up of a group of people who develop, promote, monitor, review and evaluate medication management policies and procedures.

- MACs should oversee implementation of medication reviews for residents
- MACs should oversee education activities about psychotropic medications for health and care professionals employed by the aged care provider organisation

RECOMMENDATION

Your medication regimen should be reviewed regularly. The medication review should be discussed with you and/or your substitute decision-maker. Your medication-related goals of care should be documented. Different health and care professionals should be involved in the review, including your usual prescriber.

RECOMMENDATION

Health professionals involved in prescribing, dispensing and administering psychotropic medications should undertake education about safe and effective use of these medications. Professional education programs that are structured and interactive are preferred over those that are passive and didactic. Professional education programs should be targeted to health and care professionals with different levels of health and medication literacy. Providing education as one component of multicomponent strategies to improve medication use is preferred over providing education alone.

- MACs should use data from Australia's National Mandatory Aged Care Quality Indicator Program to develop, implement and evaluate local strategies to improve the quality of medication use.

Prescribers and aged care provider organisations should implement procedures to ensure accurate documentation of prescribing and administration of psychotropic medications on electronic medication charts.

GLOSSARY

Acetylcholinesterase inhibitors

Medications that prevent the breakdown of acetylcholine, a neurotransmitter thought to be important in the chemical basis of a number of cognitive processes, including memory, thought and judgement. Acetylcholinesterase inhibitors used in clinical practice in Australia include rivastigmine, donepezil and galantamine.

Advance care planning

Planning future care to ensure that your wishes are known when you can no longer make decisions for yourself or legally complete documents.

Adverse event

Any undesirable experience associated with a medication or health intervention. Adverse events can be serious and result in hospitalisations, persistent disability or death. Adverse events are sometimes known as side-effects.

Aged care staff or worker

The Australian Aged Care Quality and Safety Commission define staff as 'People working in an organisation who are responsible for the care, administration and support of, or involvement with, consumers.' In the context of the Guidelines, staff relates to aged care staff/workers.

Antidepressant

A psychotropic medication class used to treat depression, anxiety and related conditions, such as eating disorders, obsessive-compulsive disorder and post-traumatic stress disorder. This class of medications affect a number of chemicals in the brain that influence mood and anxiety, such as serotonin, noradrenaline and dopamine.

Antipsychotic

A psychotropic medication class (also known as neuroleptics or major tranquilisers) that alters brain chemistry to help reduce psychotic symptoms. Antipsychotics can be classified as first-generation antipsychotics (also known as typical antipsychotics) or second-generation antipsychotics (also known as atypical antipsychotics).

Behavioural and psychological symptoms of dementia (BPSD)

This is a clinical term often used to describe a number of different symptoms of dementia. Behavioural symptoms may include aggression, vocalisations, restlessness, agitation, wandering, culturally inappropriate behaviours, sexual disinhibition, hoarding, cursing and shadowing. Psychological symptoms may include anxiety, depressive mood, hallucinations, and delusions. See also changed behaviours.

Benzodiazepine

A psychotropic medication class that potentiates the inhibitory effects of gamma-aminobutyric acid throughout the central nervous system, resulting in anxiolytic, sedative, hypnotic, muscle relaxant and antiepileptic effects.

Carer

People who provide the primary ongoing support and care in a non-professional, unpaid capacity for a person living with dementia. The carer is generally a spouse/partner, child, other family member, relative or friend. Not everyone in this role prefers to be referred to as a 'carer' and the person's preference should be sought before using the term. Carers should be distinguished from 'care workers'.

Changed behaviours

Dementia Australia defines changed behaviours as physical changes in the brain, and these can affect the person's memory, mood and behaviour. Sometimes, behaviour may be related to these changes, but at other times, the behaviour may be triggered by changes in the person's environment, health or medication.

Comprehensive medication review

A systematic, comprehensive and collaborative assessment of medication management for an individual person that aims to optimise the patient's medicines and outcomes of therapy by providing a recommendation or making a change. It includes the objective of reaching an agreement with the person about treatment, optimising the impact of medications, minimising the number of medication-related problems and reducing waste.

Dementia with Lewy Bodies

This a form of dementia in which dementia symptoms occur before the development of movement symptoms that are prominent in Parkinson's disease.

Depression

A mood disorder characterised by persistent sadness and a lack of interest or pleasure in previously rewarding or enjoyable activities.

Depressive symptoms

Depressive symptoms are a feature of many disorders, including depressive disorders (e.g. major depression) and bipolar disorder. Depressive symptoms cause varying degrees of functional impairment. The main depressive symptoms are low mood, or a loss of interest or pleasure in activities. Other depressive symptoms include somatic symptoms (e.g. changes to weight, psychomotor disturbance, fatigue and sleep disturbance), psychological symptoms (e.g. diminished concentration, low self-esteem, excessive guilt, feelings of hopelessness and helplessness, irritability) and suicidal thoughts or ambivalence about living.

Discontinuation symptoms

The unpleasant physical reaction that may accompany the process of ceasing medications. Also known as adverse withdrawal events, discontinuation effects, withdrawal effects and withdrawal symptoms.

Health and care professionals

Medical practitioners, nurses and allied health staff working in health and/or aged care setting.

Informed consent

A process of communication between a patient and healthcare professional about options for treatment, care processes or potential outcomes. This communication results in the patient's authorisation or agreement to undergo a specific intervention or participate in planned care. The communication should ensure that the patient has an understanding of the care they will receive, all the available options and the expected outcomes, including success rates and side effects for each option.

Medication Advisory Committee (MAC)

A multidisciplinary group of advisors to the residential aged care facility who provide medication management leadership and governance, and assist in the development, promotion, monitoring, review and evaluation of medication management policies, procedures and guidelines that will have a positive impact on health and quality of life for people in their care.

Medication chart

A tool to document a record of the prescriber's clinical intention for a person's treatment, an order for the pharmacist to dispense a person's medicine, and a record of administration of the medicine to the person.

Medication management

Practices used to manage the provision of medications, including:

- How medications are selected, ordered and supplied
- How people take medications or are assisted to take them
- How medication use is recorded and reviewed
- How medications are stored and disposed of safely
- How medication use is supported, monitored and evaluated.

Medication management occurs at both individual and services levels. Medication management has also been described as a cycle, pathway or system, which is complex and involves a number of different healthcare professionals. The person is the central focus. The system includes manufacturing, compounding, procuring, dispensing, prescribing, storing, administering, supplying and monitoring the effects of medicines. It also includes decisionmaking, and rules, guidelines, support tools, policies and procedures that are in place to direct the use of medications.

My Health Record

The secure online summary of a consumer's health information, managed by the System Operator of the national My Health Record system (the Australian Digital Health Agency). Healthcare professionals are able to share health clinical documents to a consumer's My Health Record, according to the consumer's access controls. These may include information on medical history and treatments, diagnoses, medicines and allergies.

Non-medication strategies

Interventions that do not involve the use of a medication.

Prescriber

Authorised health practitioners (for example doctors, dentists, nurse practitioners) who have completed accredited prescribing education and training that is consistent with their scope of practice, are registered with the national board for their specialty, approved under the National Health Act 1953 for prescriptions of PBS or RPBS medicines and approved under relevant state and territory legislation and regulation.

Psychosis/psychotic symptoms

A condition in which an individual is not in contact with reality. This can include sensing things that are not really there (hallucinations), having beliefs that are not based on reality (delusions) and problems in thinking clearly. DSM-5 does not include specific diagnostic criteria for psychosis in dementia.

Psychotropic medication

The Australian Aged Care Quality and Safety Commission define psychotropic medications as 'any medication capable of affecting the mind, emotions, and behaviour.' The three main classes prescribed are antidepressants, benzodiazepines and antipsychotics.

Residential aged care home

Also known as a residential aged care facility. The Australian Institute for Health and Welfare define residential aged care facility as 'A special-purpose facility which provides accommodation and other types of support, including assistance with day-to-day living, intensive forms of care, and assistance towards independent living, to frail and aged residents. Facilities are accredited by the Aged Care Standards and Accreditation Agency Ltd to receive funding from the Australian Government through residential aged care subsidies.'

Residential Medication Management Review (RMMR)

A collaborative medication review provided by an accredited pharmacist in accordance with a program funded by the Australian Government for eligible people receiving care within a government-funded residential aged care facility, consistent with the business rules for Item 903 of the Medicare Benefits Schedule. See also medication review.

Selective serotonin reuptake inhibitors

A class of antidepressant medications that increase the level of serotonin (a neurotransmitter believed to influence mood) in the brain.

Side-effect

An unintended effect of a medication. Undesirable side-effects are also referred to as adverse events. Please refer to adverse event.

Substitute decision-maker

When a person living with dementia is deemed to not have decision-making capacity there is legislation in place to ensure informed consent is obtained by a substitute decision-maker. Laws related to substitute decision-making differ across different Australian states and territories.

Supported decision-making

A process that involves supporting a person to make their own decisions about their care. Dementia Australia (https://www.dementia.org.au/planning-ahead/their-plans/key-principles) and the Cognitive Decline Partnership Centre (https://cdpc.sydney.edu.au/research/planning-decision-making-and-risk/supported-decision-making/) have produced resources about supported decision-making.

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- Canadian Family Physician Clinical Practice Guidelines: Deprescribing Antipsychotics for Behavioural and Psychological Symptoms of Dementia and Insomnia (2018)

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Disclaimer

This document is a general guide for appropriate use and practice, to be followed subject to a clinician or healthcare professional's judgement and the preferences and values of the person living with dementia. The Guideline is designed to provide information to assist decision-making and is based on the best available evidence up until April 2021.

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