September 2026 ezynews



It's time to talk about dementia



A message from the

Managing Clinical Pharmacist

This September, we recognise **Dementia Action Week, 21–27 September 2026**. It reminds us that quality dementia care begins with seeing the person, understanding their individual needs and responding with compassion. At **Ezymed**, we remain committed to safer medicines, informed choices and care that protects dignity and quality of life.

Inas Karem

There are an estimated **446,500 people currently living with dementia in Australia**, and this is only expected to increase in the future.

What is Dementia?

Dementia is not a single condition but a **syndrome** characterised by progressive cognitive decline, affecting memory, reasoning, communication, and the ability to perform daily activities.

Dementia should not be considered a 'normal' part of ageing. Although it's more common after 65 years of age, it can happen to anybody.

It's essential that you have an awareness of dementia, as it is a growing epidemic in Australia.

Dementia in Numbers

- Dementia is the **leading cause of death** in Australia.
- It's the **leading cause of death in Australian women.**
- **Aboriginal and Torres Strait Islander people are three to five times more likely to develop dementi**a compared to non-Indigenous Australians.
- Almost **1.7 million people** in Australia are **involved in the care of someone living with dementia**.
- **54% of permanent aged care residents** in Australia are living with dementia.

Common Types of Dementia

- **Alzheimer's disease** – the most common, with hallmark memory loss and disorientation.
- **Vascular dementia** – caused by reduced blood flow to the brain; may follow a stroke.
- **Lewy body dementia** – often presents with hallucinations, sleep disturbance, and movement symptoms.
- **Frontotemporal dementia** – impacts behaviour, personality, and language, often with earlier onset.
- **Mixed dementia** – features more than one type, commonly Alzheimer's and vascular.

Early Symptoms & Features

- Short-term memory loss
- Difficulty with planning or problem-solving
- Word-finding difficulties
- Disorientation in time and place
- Personality or behavioural changes
- Reduced judgment and decision-making





Management & Treatment

Current Treatment Approaches

While dementia remains incurable, treatment aims to slow progression, manage symptoms, and improve quality of life.

Non-pharmacological Interventions (First-Line)

- ✓ Cognitive stimulation and reminiscence therapy
- ✓ Structured daily routines
- ✓ Exercise and social engagement
- ✓ Nutrition optimisation and sleep hygiene

Pharmacological options

Acetylcholinesterase Inhibitors

- **Donepezil (Aricept® / generic)** – Can this please be changed to 5mg in the evening, may increase to 10mg in the evening after 4-6 weeks
- **Rivastigmine (Exelon®)** –
  - » Capsules: start 1.5 mg BD, titrate to max 6 mg BD
  - » Patch: 4.6 mg/24h → 9.5 mg/24h → 13.3 mg/24h
- **Galantamine (Reminyl® / generic)** – initially 8 mg once daily in the morning for a minimum of 4 weeks, then 16 mg once daily in the morning for a minimum of 4 weeks. Maximum, 24 mg daily

NMDA receptor antagonist

- **Memantine (Ebixa® / generic) –** start 5 mg daily, increase weekly by 5 mg to 20 mg/day (10 mg BD)

Adjunctive / Symptomatic therapies (used with caution)

- **Antidepressants**
  - » **Sertraline (Zoloft®)** 25–100 mg daily
  - » **Citalopram (Cipramil®)** 10–20 mg daily
  - » **Mirtazapine (Avanza®)** 15–45 mg nocte (for mood, appetite, sleep)
- **Antipsychotics (BPSD only, time-limited)**
  - » **Risperidone (Risperdal® / generic)** 0.25–0.5 mg BD, max 2 mg/day
  - » **Quetiapine (Seroquel®)** 12.5–25 mg BD, up to 100 mg/day

(Use shortest duration possible; requires documentation of restrictive practice if ongoing)

- **Benzodiazepines (short-term only, high risk)**
  - » **Oxazepam (Serepax®)** 7.5–15 mg nocte/PRN
  - » **Temazepam (Temaze® / generic)** 5–10 mg nocte PRN

Reminder: Antipsychotics for BPSD are considered a restrictive practice. Their use must be time-limited, documented, consented, and regularly reviewed in line with the Aged Care Quality Standards.

Role of Care Teams

- **Nurses and carers:** monitoring and support daily function, Monitor for sudden change in behaviour, engaging in communication.
- **Pharmacists:** medication review, deprescribing inappropriate agents, monitoring for adverse effects.
- **Allied health:** physiotherapy, occupational therapy, speech pathology – supporting mobility, independence, and communication.
- **Families:** providing emotional and social support.



BPSD (Behavioural and Psychological Symptoms of Dementia)

Understanding BPSD

Up to 90% of people with dementia will experience BPSD at some stage. Symptoms may include:

- Agitation, aggression
- Depression, apathy
- Hallucinations or delusions
- Wandering and restlessness
- Sleep disturbance

Management Principles

1 Identify and address triggers

- Pain, infection, constipation, medication side effects, environmental overstimulation, unmet needs.

2 Identify and address triggers

- Calm, structured environment
- Validation and reassurance therapy
- Music, art, or pet therapy
- Regular physical activity
- Staff training in de-escalation techniques

3 Pharmacological treatment (last resort)

(time-limited, lowest dose, careful monitoring)

Antipsychotics

- Risperidone (Risperdal®) 0.25–0.5 mg BD, max 2 mg/day
- Quetiapine (Seroquel®) 12.5–25 mg BD, max 100 mg/day

(Use shortest duration possible; requires documentation of restrictive practice and into behaviour support plan)

Antidepressants (for mood or anxiety symptoms)

- Sertraline 25–100 mg daily
- Citalopram 10–20 mg daily

Benzodiazepines (only for acute crisis)

- Oxazepam 7.5–15 mg nocte/PRN
- Temazepam 5–10 mg nocte PRN

Reminder: The use of antipsychotics in BPSD is classed as a restrictive practice. Ensure:

- Informed consent is obtained and documented
- Use is regularly reviewed
- Non-drug strategies are always prioritised first



RESTRICTIVE PRACTICE CONSIDERATIONS & EZYMED'S ROLE

The **Aged Care Quality and Safety Commission** requires that restrictive practices (chemical, physical, environmental) are a **last resort** and must:

- Be clinically justified and documented within their Behaviour support plan
- Have informed consent from the person or their substitute decision-maker
- Be documented with review dates and ongoing monitoring

Examples:

- Chemical restraint – e.g., risperidone for severe agitation
- Physical restraint – e.g., bedrails, lap belts
- Environmental restraint – e.g., locked doors or restricted access

Risks: reduced mobility, falls, sedation, worsened confusion, decreased quality of life.

Our Commitment at Ezymed

- Conducting **comprehensive RMMRs** to identify inappropriate use of psychotropics.
- Supporting facilities to comply with **restrictive practice regulations.**
- Benchmarking psychotropic use across facilities to drive quality improvement.
- Providing **staff education** on non-pharmacological strategies for BPSD.
- Ensuring deprescribing pathways are explored wherever safe and appropriate.



Dementia care requires compassion, vigilance, and a multidisciplinary effort. Through awareness, education, and evidence-based practice, we can reduce unnecessary medication use, support residents living with dementia, and ensure aged care facilities meet both clinical and ethical obligations.

For further resources or staff training on dementia management and BPSD, please contact the **Ezymed Clinical Team on info@ezymedmm.com.au**