Submission 166

STANDING COMMITTEE
11 JUL 2003
ON AGEING

55/4 Macleay St
Potts Point
NSW 2011

07/07/03

The Secretary
House of Representatives
Committee on Ageing
Parliament House
Canberra ACT 2600

Dear Allyson,

I would like to thank the Chairman, Dr Southcott, and other members of the Committee for enabling me to take part in last week's public hearing in Sydney. It was really interesting to listen to the other witnesses and to gain new perspectives on the Committee's work.

I would appreciate it if you could draw some additional comments I have made in the attached addendum to the Committee's attention. They refer to matters raised during my session and seek to clarify comments I made. Apologies for the writing.

Thank you also for your assistance in explaining the Committee's processes.

Yours sincerely Patti Ham

Addendum to Submission
to House of Representatives Committee on Ageing.

During my session, Ms Hall asked me to comment further on my concerns about medication being prescribed without the benefit of accurate medical histories being taken, before clinical trials were completed and without proper recording and reporting of side effects.

I would like to record that my friend was prescribed Olanzapine by a visiting psychiatrist in his first week in the nursing home in May 2000 and the medication was not stopped until the last week of his life in December 2001, clearly long after it was required, given his enfeebled condition. His treating G.P. at the nursing home had admitted he was not familiar with the medication and since he was also not familiar with his new patient and his medical history, it was hardly an ideal clinical situation. It seemed to me that the effects of this medication were never properly monitored.

At the same time, in Melbourne, the husband of the registered nurse whose case I mentioned in my oral evidence, was showing signs of significant deterioration which appeared inexplicable according to the drug charts she inspected. Only after extensive inquiries did she establish that her husband, who had early onset Alzheimers, had been enrolled, without her knowledge, in a clinical trial of Olanzapine. As next of kin, she had not been consulted and no consent had been given for his participation in the trial, for which separate records were being kept. This was in 2000, the year my friend was prescribed the same drug.

Research published in the British journal Age and Ageing in February 2003 and reported in the Guardian Weekly of 13-19 February 2003 stated

that over 80 percent of elderly people in a sample of British nursing homes had been prescribed strong tranquillisers with no proper medical justification. The neuroleptic drugs – administered to quieten patients with what staff called 'behavioural problems' – were likely to make their dementias worse and risked them breaking hips or other limbs, according to the five doctors in london teaching hospitals doing the research. The study of nearly 1000 patients over 65 found that medical notes showed the prescription were not appropriate therapy for 82.8 per cent of those who received them and more than half had not been reviewed for six months. Community activists lamented the use of medication as a weapon, claiming patients were victims of 'a chemical cosh'. The Alzheimers Society said that the finding was true of old people in homes across Britain and could apply to up to 100,000 of the 500,000 in residential care.

Given the comments made by Professor Le Couteur in his oral evidence about the hospital admissions here resulting from inappropriate medication, adverse drug reactions and polypharmacy, it may be time to recommend a similar study on inappropriate medication of elderly people in Australia. This would ultimately benefit all nursing home residents and could relieve the huge financial burden on the P.B.S. and the public hospital system.

I would also like to comment further on the tyranny of distance affecting the location of nursing homes which exacerbates the loneliness of old age.

An elderly neighbour of mine moved from Mudgee to Potts Point to be closer to her daughter after her husband died a few years ago. Severely arthritic, she rarely ventured outside her fifth floor unit. Following a change to her blood pressure medication a year ago, she had several falls and

moved to live next door to her daughter in Elizabeth Bay. Away from more familiar surroundings, she became confused, fell again and was admitted to St Vincents Hospital. Assessed as needing nursing home care she was discharged to a nursing home where, less than 24 hours later, she fell and broke her hip. This time she was taken to Royal Prince Alfred Hospital, where her hip was set and she remained some fortnights before being transferred to Balmain Hospital for rehabilitation. Her daughter visited many more nursing homes before deciding one she considered of an acceptable standard at Dulwich Hill, some ten suburbs away. Settled there, eventually my old neighbour regained some of her confidence and attained some contentment. A month ago, this nursing home was put on the market. She is now trying to come to terms with another move, this time to Marrickville and, like all the other places, a long way away from Mudgee, where she was part of a caring, familiar community and which she regrets having ever left. The reason for her move to Sydney had been to be closer to her daughter; now she sees her twice a week. The last year has been very difficult for both of them, but at least they are within the same city and public transport <u>is</u> adequate.

It is much more difficult for relatives and friends stranded by circumstance, illness and age, across the country. I am able to visit the elderly aunt of a Tasmanian friend who frets about her beloved aunt's isolation in a Sydney nursing home. My friend is prepared to visit my own elderly aunt, an old teacher, who lives in Hobart in her own home. Maybe we need <u>a</u> national scheme encouraging people to 'Adopt an Aunt', especially those often unmarried old teachers and nurses who so often finish up in nursing homes because there is no immediate family to help. Perhaps the nursing and teaching unions could consider asking local nursing homes whether there are any unvisited residents who might welcome some ongoing companionship from their old peers.

In relation to the need for an ongoing public education campaign on ageing and dementia, as attempted by Alzheimers Australia and urged by Professor Le Couteur in his oral evidence, I believe there should be some emphasis on the fact that a diagnosis of dementia is not an immediate death sentence. Too many people believe that once a nursing home door shuts on a dementia patient that there is no point in any further contact. Families and friends need to be encouraged to make the most of the time left for real connections of body, mind and spirit. Adult children and grandchildren need to hang onto real, positive and loving memories through affectionate interaction before it is <u>too</u> late. Sadly, some medication makes this connection harder by transforming relatives into sadly stooped, shuffling, drooling strangers and more sensitive and accurate prescribing should be an urgent priority for treating doctors.

Finally, courses in basic first aid and personal care should be freely available through TAFE and community groups to give everyone more confidence in coping with the challenge and opportunity as carers for relatives, friends & neighbours in distress.