

William's Story

William has dementia. After suffering a stroke, his memory loss and disorientation increase and he shows anxiety and aggression. He reacts badly to antipsychotics given in the hospital, so this medication is stopped. This information, however, is not communicated to his GP who prescribes William these same antipsychotics. William's condition rapidly deteriorates.

Can we do better?

How might we better communicate the rationale behind medication choices, medication history and any adverse reactions?

William was a seventy-four-year-old who was recovering from a stroke and had dementia. Prior to his stroke he had been living at home with his partner, Jill, and was physically able, though he had some memory loss due to the onset of dementia.

After the stroke, William had reduced mobility in his left side and his memory loss and disorientation worsened. The recovery period in hospital was long—sixteen weeks—and during this time his behavioural impairments were increasingly difficult to manage. He became aggressive and easily anxious and was restrained for several weeks while doctors regulated his medication. The agreed goal for his care was to enable him to manage and maintain appropriate social interaction, control impulsive behaviour, and improve anger management. The stroke had impaired William's insight into what was appropriate behaviour. He reacted to some medications, so there were many adjustments before the optimum combination of medications were achieved.

The rehabilitation he received focused on ensuring he could attain some independence in terms of feeding himself and taking care of some basic hygiene.

His family were supportive and were involved in the decision around his care, agreeing to transfer him into the dementia wing of a residential aged-care facility (RACF).

Basic information and existing medication sheets were exchanged between the hospital and the RACF. His GP had not been consulted at any time throughout the hospital stay or the transfer. No mention was made of the difficulty of achieving the correct medication doses.

The family were asked by nursing staff to provide basic information about William, and it was soon obvious that the information provided by the hospital was minimal, and really only provided a snapshot of William's condition at the time of transfer.

William was initially content with his new environment, interacting appropriately with staff, other residents and his family. He was able to feed himself and maintain his own hygiene with minimal assistance. However, once he realised he was not going home after the first week, he became highly agitated and aggressive, and started throwing things at staff.

His GP—who hadn't received the full history from the hospital—was contacted. He consulted with a colleague who had experience in aggressive behaviours in dementia patients, resulting in a change of medications from the successful combination that had been achieved over several weeks.

William had reacted badly to the anti-psychotics he had been given in hospital; they sedated him and further reduced his cognitive function. Unaware of this, the GP prescribed these same medications, and William declined quickly; he was drowsy—falling asleep whilst standing—and could no longer feed himself. He suffered two falls and became more withdrawn, finally becoming bed-bound.

William died five weeks after his transfer.