**STOP-DEM – Deprescribing for People with   
Cognitive Impairment**

**Transcript**

**HP10**

INT:  
Can you tell me about the care you provide to people with dementia or mild cognitive impairment, please?

PARTICIPANT:  
OK, so same there's two types of care that I provide and it depends on what it is. So I do antipsychotic reviews for people they've got dementia. So for things like BPSD, I don't know if you know what that is, so it's like behavioural psychological symptoms that happens when we have dementia and what I do in that case is review them every three months and then if the symptoms has reduced or the resolved, I start reducing and eventually stop the anti psychotic medication and I make sure that the blood test, like the production, everything is up to date and any pharmacy issues there.

PARTICIPANT:  
I stop it, you know, reduce the PO body. On the other hand is medication review.  
So when I do medication review, I work with a dementia care team.

PARTICIPANT:  
We have a PCN one here, and then what we do is when they see a patient and they go and visit after the visit, then they can come back to me and say can we review this patient please and maybe they have like a high anticholinergic burden.

PARTICIPANT:  
Then I speak to the carers and then review the medication accordingly and if I find that safe, for instance that I am things like carrots stress that wasn't mentioned whilst our team, the Dementia Care team is visited them, I will raise that as well.

INT:  
OK.

PARTICIPANT:  
So these are the two things I tend to I do with dementia and patience.

INT:  
Thank you.

INT:  
And how much of your workload is this please?

PARTICIPANT:  
I would say probably 20% of my workload.   
But like for instance, the antipsychotic reviews, I don't do it all the time, I do it every three months.

PARTICIPANT:  
So, and it's an ongoing, I'll just say about, yeah, about 20%.

INT:  
And how many of the people are taking multiple medications?

INT:  
Umm.

PARTICIPANT:  
I think quite a lot of them on multiple medications, it's quite rare to see a dementia patient that is only just on one medication. They do exist, but there are more than you know.

PARTICIPANT:  
One or two medications you should.

INT:  
And what are your views regarding deprescribing of inappropriate medication among people living with dementia or mild cognitive impairment?

PARTICIPANT:  
I think that I'm deprescribing where appropriate is a good thing.

PARTICIPANT:  
For example, I did mention an anticholinergic burden.

PARTICIPANT:  
It's something that, you know, we should look at because at high anticholinergic burden leads to you.

PARTICIPANT:  
You know what you call that?

PARTICIPANT:  
Recurrent falls, which is not good for a patient.

PARTICIPANT:  
So yes, deprescribing where appropriate.

PARTICIPANT:  
Is good and sometimes you can see an example.

PARTICIPANT:  
It will be, you know, for all.

INT:  
Mm-hmm.

PARTICIPANT:  
So say for instance someone is on 3200, the loading dose for example, and you take that for like 12 weeks, but sometimes they will just be on it for longer without any reason.

PARTICIPANT:  
So when you go there, you just stop it because it's no longer appropriate, or if you find out that the medications that they are on is causing low blood pressure or high blood pressure is something that you can maybe stop for certain amount of time.

PARTICIPANT:  
So everything is in. In summary, what I'm saying is deprescribing is good if is-  
Well, it where clinically appropriate.

INT:  
Thank you.

INT:  
And can I just take the name of that, that drug again that you mentioned there.

PARTICIPANT:  
Calciferol is just vitamin D. It's just getting me D, but sometimes when we do load in those you know you do it for three months and after three months you drop down to the managing what you call. I can't even find my word for the ones that you just maintenance those.

PARTICIPANT:  
That's the word.

INT:  
Umm.

PARTICIPANT:  
So you drop down to maintenance, but sometimes that is missed.

So you just said go back in and change it or stop it.

INT:  
OK.

INT:  
Thank you.

INT:  
And any other advantages to deprescribing?

PARTICIPANT:  
Is it just based on? dementia. Right.

INT:  
Yes, yes, but that population please.

PARTICIPANT:  
OK.

PARTICIPANT:  
I mean apart from.

PARTICIPANT:  
You know what I talked about and.

INT:  
Umm.

PARTICIPANT:  
What I bought for what I thought about anticholinergic burden, other advantage will include, you know, in dangerous drugs like things like anti-inflammatory, non steroidal in things like benzodiazepine as well and.

PARTICIPANT:  
Contagious. Also, that improves the overall well being of the patient and he blows the mortality rates of a patient.

INT:  
Yeah.

PARTICIPANT:  
So I mean, this is just the things I can think of in my head now, but you know reduces have you vascular events.

PARTICIPANT:  
This is certain medications that if you leave patient and it's not appropriate for them, they can lead to other things that we don't want, so.

PARTICIPANT:  
Like I said, falls risks reduces mortality risk, reduces cardiovascular events.

PARTICIPANT:  
So that's what I can think of at the moment.

INT:  
Thank you.

PARTICIPANT:  
OK.

PARTICIPANT:  
Hmm.

INT:  
And on the other hand, for that same population, people with dementia or mild cognitive impairment, are there any challenges of deprescribing of inappropriate medication?

PARTICIPANT:  
Yeah, there are challenges because.

PARTICIPANT:  
Sometimes when you deprescribe medication.

PARTICIPANT:  
After a while you find out, uh, maybe they still need it.

PARTICIPANT:  
An example will be respired out.

INT:  
Mm-hmm.

PARTICIPANT:  
For example, we do use risperidone as first line in our formulary to manage PSD and many a times say for instance if a patient is agitated for example, we can give them the risperidone and then after a while if the symptoms resolved, we start taking it away because you know long term there's a risk of stroke, there's a risk of death or the on that.

PARTICIPANT:  
So when we start reducing it, you find OK, fine.

PARTICIPANT:  
We've reduced this and then maybe a month or two later.

PARTICIPANT:  
The symptom scripts off again, so we have to go back again if that makes sense.

INT:  
Umm.

PARTICIPANT:  
So that's one.

PARTICIPANT:  
Another one will probably be.

PARTICIPANT:  
Things like, say for instance, if they're not sleeping, for example, you give them some, I don't know, all they're not sleepy.

PARTICIPANT:  
Give them some sleeping medications sometime for just for a very short while.

PARTICIPANT:  
You can find out that because they are old, obviously the organisms are not metabolizing medication as fast as you know issue it would be someone is like I don't know 18 or something like that.

PARTICIPANT:  
So in that situation, if we give them those medication for short period of time, you find out they start having what we call sundowning sometimes.

PARTICIPANT:  
And then you have to go back.

PARTICIPANT:  
Is it that you stop?

PARTICIPANT:  
Stop the medication and after a while the sun down and goes.

PARTICIPANT:  
But you find that they stop the lack of sleep comes back again.

PARTICIPANT:  
I don't know if I'm making sense.

PARTICIPANT:  
What I'm trying to explain.

INT:  
Umm, yeah, yeah, but what?

INT:  
I'm sorry.

INT:  
What?

INT:  
What does sundowning refer to please?

PARTICIPANT:  
Ohh, I'm sorry some darling.

INT:  
No, that's no.

PARTICIPANT:  
So Sundowning is safer instance and it's a term that we use that changes in behaviour of a patient, especially if they have dementia.

PARTICIPANT:  
So in the IT happens maybe in the afternoons or evenings so they can become confused or hallucinates, or just sleep a lot or things like that.

INT:  
Good.

INT:  
Mm-hmm.

PARTICIPANT:  
So sometimes that happens and then you look at the medications that they are on and say ohh maybe we can reduce this or stop this for a while so that they can, you know be able to function better and be able to attend you know like the classes that.

PARTICIPANT:  
I don't know if you know the classes they go to sometimes.

INT:  
No, no. Yes.

INT:  
Umm.

PARTICIPANT:  
You know, so we can, you know, they sometimes go to classes where then, like, cognitive classes, they will do things like that or meet half ago.

PARTICIPANT:  
What the name is called noun.

INT:  
Sure.

PARTICIPANT:  
If I remember it, I will tell you, but there are few classes that I am they go to just to help you know.

PARTICIPANT:  
They move around, help their brain and cognition.

PARTICIPANT:  
Is that the words here so?

INT:  
Umm.

PARTICIPANT:  
That's it.

PARTICIPANT:  
   
INT:  
No memory clinics?

PARTICIPANT:  
That's it.

PARTICIPANT:  
That's the what.

INT:  
No, not I.

INT:  
Was it? Yes.

PARTICIPANT:  
No, we're clinic is the one that I'm like, yeah.

INT:  
I knew what you meant.

INT:  
Yeah. Yeah.

INT:  
So though that those so you mentioned about Sundowning and.

INT:  
Yep.

INT:  
So those choosing medications to help with that is that right?

PARTICIPANT:  
Yes.

INT:  
Yeah.

PARTICIPANT:  
So if someone is having like sundown in is either you know, reduce the medication, you just have to look at it on an individual basis.

INT:  
Mm-hmm.

PARTICIPANT:  
Yeah.

PARTICIPANT:  
So if say for instance you find that they are hallucinating more or they're sleeping too much, and in the afternoon and then at night they're not sleeping in all things like that.

INT:  
Mm-hmm.

PARTICIPANT:  
So it just changes in behaviour and then you have to look at.

PARTICIPANT:  
OK.

PARTICIPANT:  
Is there anything that I can do to either add the medication or stop a certain medication to make give the patient a better quality of life basically.

INT:  
Umm OK, thank you.

INT:  
And what types of medications would you feel most comfortable deprescribing for people living with dementia or mild cognitive impairment and why?

PARTICIPANT:  
I think I would go with antipsychotics.

INT:  
Umm.

PARTICIPANT:  
And the reason is because I've I do a lot of reviews on them, some comfortable either it's, you know, stopping them for the patient and monitor all initiating.

PARTICIPANT:  
But most of the time when we start doing this cause the way.

PARTICIPANT:  
The way we walk down here is if a patient has like symptoms, we refer them to PMH and then OP MH will initiate what needs to be initiated and then once the patient is discharged, we now take over the management.

PARTICIPANT:  
So if a patient is discharged with say for instance risperidone and we know that we need to and monitor it every three months because of the risks associated with it.

PARTICIPANT:  
Then, once the symptoms resolved, so say for instance if a patient is on, we've Spiridon for maybe agitation or aggression and things like that.

PARTICIPANT:  
I can then go in at month three and say see how the patient is getting on.

INT:  
Umm. PARTICIPANT:  
If everything is OK and the symptoms is resolved, then I do slowly very slowly reduce the medication whilst monitoring, making sure that the symptoms it's not there so antibiotics are happy to either reduce the prescribe or initiate if need be with initiated sometimes and then things like.

PARTICIPANT:  
Your lorazepam

PARTICIPANT:  
So Z drugs.

PARTICIPANT:  
I'm happy to reduce them and monitor patient or initiate as well if clinically appropriate.

INT:  
OK.

INT:  
So that was that.

INT:  
You never used the Pams.

INT:  
Yeah.

INT:  
Yeah.

PARTICIPANT:  
Lorazepam.

INT:  
Central your assumption.

PARTICIPANT:  
Lorazepam here.

INT:  
Are you the pan and said drugs?

INT:  
Yeah.

INT:  
Yeah.

PARTICIPANT:  
Yes, said drugs.

INT:  
OK.

INT:  
Thank you.

PARTICIPANT:  
What?

INT:  
And is there anything that would encourage you to support reducing or stopping and medication?

PARTICIPANT:  
Can you ask that question again please?

INT:  
Yeah, sure.

INT:  
Yeah.

INT:  
Is there anything that would encourage you or to support reducing or stopping a medication?

PARTICIPANT:  
And this quite a few things.

PARTICIPANT:  
I mean the first thing is if there's a polypharmacy, there's a lot of tablets.

PARTICIPANT:  
We look at it and review it and see ways that we can reduce the pure body if clinically appropriate.

PARTICIPANT:  
And then there's other things like.

PARTICIPANT:  
Reviewing the medication and seeing that these medications are not appropriate.

INT:  
Mm-hmm.

PARTICIPANT:  
For example, if a patient keeps having recurrent falls, we need to look at it and find out why are they having falls.

PARTICIPANT:  
Is there a medication?

PARTICIPANT:  
Is there something else that is ongoing that we don't know about?

PARTICIPANT:  
So things like that, it's just looking at what's going on at the particular moment, because it has to be like an individual or an individual basis basically.

PARTICIPANT:  
So I look up why?

PARTICIPANT:  
What is going on?

PARTICIPANT:  
Or sometimes you know in.

PARTICIPANT:  
Deprescribing lawsuit would be just through referral off by another colleague.

PARTICIPANT:  
Like I said to you, that are dementia team.

INT:  
Mm-hmm.

PARTICIPANT:  
My gun home visit and they pick something up and they ask me, can I actually look at this patients medication and see if there are ways that we can.

PARTICIPANT:  
Change things.

PARTICIPANT:  
So make things a bit better.

PARTICIPANT:  
I don't know.

PARTICIPANT:  
Did I answer your question?

INT:  
Yes, yes, certainly, definitely.

INT:  
Thank you.

INT:  
And what medications would you be reluctant to deprescribe and why please?

PARTICIPANT:  
So

PARTICIPANT:  
So the medication it.

PARTICIPANT:  
Umm.

PARTICIPANT:  
It's not a lot of them that I will be reluctant to deprescribe.

PARTICIPANT:  
Like I said, it just depends on and what the situation is and monitoring patient, but I think you know things like the medications that we use mainly for management of dementia or Alzheimer's.

PARTICIPANT:  
Do you know what I'm talking about?

INT:  
But if you could give some excellent.

PARTICIPANT:  
Like you're the mountain, you know, like my mountain.

PARTICIPANT:  
Like, it's like a glutamate receptor antagonist.

INT:  
OK, sorry.

PARTICIPANT:  
Sorry, not antagonist sees that.

INT:  
Can I just take that drug name again?

PARTICIPANT:  
He's my mountain is memantine, say MEMANTINE.

INT:  
Yep it.

INT:  
Umm.

PARTICIPANT:  
So I'll be reluctant to stop those types of medication or things like Donepezil, so I'll be reluctant to stop them only because, you know, in in a down our area is usually initiated by the secondary care and then we take over the management.

PARTICIPANT:  
So if there's, if I notice that that there's a problem or that the other things that we can do, I always seek advice or refer patient back to the OPM H.

INT:  
That's the.

INT:  
Oh, it's the old person's mental health.

PARTICIPANT:  
OK, this mental health team? Yeah.

INT:  
But maybe yeah, yeah, yeah.

INT:  
OK.

INT:  
Thank you and.

PARTICIPANT:  
Worries.

INT:  
What?

INT:  
What's the main things that you think need to be in place for successful deprescribing for someone with dementia or mild cognitive impairment, please?

PARTICIPANT:  
Say that again please.

INT:  
Yeah, sure.

INT:  
What are the main things?

PARTICIPANT:  
Hmm.

INT:  
What are the main things that you think that you think need to be in place for successful deprescribing for someone with dementia or mild cognitive impairment?

PARTICIPANT:  
OK so.

PARTICIPANT:  
The first one we need to make sure that they are bloods are up to date before you start deprescribing any medication.

PARTICIPANT:  
So block test needs to be up to date.

PARTICIPANT:  
This includes the liver function test, kidney function test, full blood counts.

PARTICIPANT:  
All those needs to be in place and then.

PARTICIPANT:  
And we need to make sure that the observations are done and what I mean is, I mean up to date observations.

PARTICIPANT:  
So what I mean is like the weights, their height, their blood pressure needs to be in place because for example like things like weights, we will use that to calculate the creatinine clearance to make sure that the dosage of medication that they are on is appropriate.

INT:  
Umm.

PARTICIPANT:  
So that is important.

PARTICIPANT:  
Also, we look at the notes, so a letters from all PMH.

PARTICIPANT:  
OH, and discharge letters from hospitals because sometimes you know in discharge letters they will tell you what they want you to do or why something happened and then that.

PARTICIPANT:  
Helps as well.

INT:  
OK.

PARTICIPANT:  
And also just a good multidisciplinary team as well because you can't do this just by yourself.

INT:  
Mm-hmm.

PARTICIPANT:  
You need other people you work with.

INT:  
Thanks.

PARTICIPANT:  
So I think everything put together will make a good deprescribing its success.

INT:  
Thank you.

INT:  
And please describe your experience of having deprescribing discussions with people living with dementia or mild cognitive impairment or their informal caregivers, please.

PARTICIPANT:  
Umm, so usually when I speak to.

PARTICIPANT:  
And patient, I don't mean that I speak to the patient directly.

PARTICIPANT:  
I speak to the caregivers.

INT:  
Umm.

PARTICIPANT:  
Uh, and usually that the child, the child or the wife or the partners or someone that's got power of attorney.

PARTICIPANT:  
So I discuss, you know, their medications, what we need to change overall health, are they eating and drinking well because sometimes in difficult swallowing difficulties can happen once when this the disease starts to progress.

PARTICIPANT:  
So there's a few things that I discuss with them and my experience so far has been good, no issues because.

PARTICIPANT:  
At the end of the day, what we're doing is to help out in, you know, what's the right word to make their life.

PARTICIPANT:  
And see.

PARTICIPANT:  
Give them a better quality of life and making sure that the medication that are on is appropriate.

PARTICIPANT:  
Uh, nothing is overprescribed.

PARTICIPANT:  
And then I think that's it.

INT:  
Thank you.

PARTICIPANT:  
Just what I can come up with in my head.

INT:  
Thank you.

PARTICIPANT:  
What I did, that's fine.

PARTICIPANT:  
Hmm.

INT:  
That that's what's thank you and that those discussions that you have, what works well about them, what works well about those discussions.

PARTICIPANT:  
I think when we have the chat, for example in, if we are doing let's say a 3 monthly check up and it gives them the opportunity, the carers to say OK, tell us how the patient is, is the disease progression at a faster rate?

PARTICIPANT:  
What has changed?

PARTICIPANT:  
Is anything.

PARTICIPANT:  
Is the things are still the same or is anything changed so and then it's just when we do that review the thing that works well, it's just looking at things more realistically just to make sure that patient is OK and they're getting the care that they need.

PARTICIPANT:  
And so I would say.

PARTICIPANT:  
What works well is just.

PARTICIPANT:  
Having a discussion with the carer and making sure that the patient is OK and that what we're doing like the medications is helping and is that there's an opportunity to let us know if something is not working.

PARTICIPANT:  
And I know you're going to ask me.

PARTICIPANT:  
What?

PARTICIPANT:  
Don't what? Well.

INT:  
Yes.

INT:  
That's the next one, yeah.

PARTICIPANT:  
So I mean sometimes in it could just be safe, for instance, that they've run out of medication, for example, and they put in the repeat request, but they put it late.

PARTICIPANT:  
So you come to the review and they're ready saying ohh I haven't got the medication.

PARTICIPANT:  
They've not had their something for their VPS for two days.

PARTICIPANT:  
I will kind of like panicking to make sure that the patient gets their medication.

PARTICIPANT:  
You know what the carriers will say sometimes so.

INT:  
Umm.

PARTICIPANT:  
At that particular point, that don't really work so well because you don't want the patient to go back to what their symptoms are were before they are on those medications.

INT:  
Umm.

PARTICIPANT:  
So you have to, you know, make sure that medication they get that medication on time and make sure that patient is taking the medication so that they don't go back.

INT:  
Umm.

PARTICIPANT:  
I don't know if I'm making sense, so they don't go back to what the symptoms are.

PARTICIPANT:  
So say for instance someone is on respirator for agitation and their carers put the prescription in late and it takes about at least five working days for it to be processed.

PARTICIPANT:  
That leaves the patient for a few days without having the medication.

INT:  
Mm-hmm.

PARTICIPANT:  
So that puts us in, you know, she likes saying this situation where we are trying to hurry to get their medications so that the patient will start taking the medication.

PARTICIPANT:  
And in these situations, I mean when this happened in the past, I've just said, you know, we're gonna pop you and repeat dispensing so that that way you just get it at a certain time of the month every month until when we do the review to say the symptoms have resolved.

INT:  
Mm-hmm.

PARTICIPANT:  
We are stopping this so.

INT:  
Thank you.

PARTICIPANT:  
That's more like you say that the only time it didn't really go well.

INT:  
OK.

INT:  
Thank you. INT:  
And it's would, would you say you have the majority of those discussions with the, was it the, the family caregiver or with the patient as well as deprescribing discussions?

PARTICIPANT:  
I mean, I do have the and the discussions we mostly the primary care giver, because if someone has got dementia, some of them still have a.

PARTICIPANT:  
What was the what?

INT:  
Capacity.

PARTICIPANT:  
I can't remember the what city.

PARTICIPANT:  
That's the one.

INT:  
Capacity. You.

PARTICIPANT:  
That's what they're looking for.

PARTICIPANT:  
So some of them still have capacity, but to discuss in depth about their medications, they won't remember so.

PARTICIPANT:  
But if I do a home visit, I still I can't leave the patients.

INT:  
Umm.

PARTICIPANT:  
How to chat with them and most of them still remember their date of birth.

PARTICIPANT:  
Some of them, even their address sometimes.

PARTICIPANT:  
But when it comes to the call, the main thing about the medications and their healthcare, I tend to discuss it with the people that have the power of attorney or their main carers.

INT:  
Thank you.

INT:  
And just thinking.

INT:  
Who do you think is best place to be involved in deprescribing discussions in primary care for people living with dementia or mild cognitive impairment?

PARTICIPANT:  
Hmm.

INT:  
Who? Who?

INT:  
Who's best place to be involved in those discussions?

INT:  
Deprescribing discussions.

PARTICIPANT:  
I it's pharmacists.

PARTICIPANT:  
I think pharmacists bought then.

PARTICIPANT:  
You also need the mental health team.

INT:  
Umm.

PARTICIPANT:  
It's well, so like I said earlier, wrong, we do work with dementia team and mental health team, which is the PM H and the pharmacy team.

PARTICIPANT:  
We do get the GP's involved but when we are deprescribing so we discuss what we need to do, what we need to action and then make the GPU aware like run it through the GP and GP will say, yeah, we're happy carrier and then we just go ahead and make the changes.

PARTICIPANT:  
So thinking about it is not only the pharmacist, but I think pharmacists should be involved in deprescribing because we're expecting drugs.

,….  
INT:  
Thank you.

INT:  
And are there any professional groups who should or should not be involved?

INT:  
One or the other.

PARTICIPANT:  
And.

PARTICIPANT:  
Not really.

PARTICIPANT:  
I think healthcare professionals should be involved because and it's just like, does that deal with medications the nurses like, if the nurses goes on, what round are prescribing nurse?

PARTICIPANT:  
They do get involved because they might pick up something that is not necessarily need to be there, or that that not necessarily that they should be using.

PARTICIPANT:  
She can say ah, we need to stop.

PARTICIPANT:  
This is it.

PARTICIPANT:  
OK.

PARTICIPANT:  
Yeah, we'll stop that.

INT:  
Umm.

PARTICIPANT:  
So I don't think I think anyone that deals with patients, patient care or their medication should be involved in the deprescribing.

INT:  
That's it.

PARTICIPANT:  
But the way we work, we all work as a team, so we tend to run things through each other about she's that bouncy things they should through each other.

PARTICIPANT:  
That makes sense.

PARTICIPANT:  
And then we'll go for it.

INT:  
Thank you.

INT:  
And who is best place to lead the discussion?

PARTICIPANT:  
No.

INT:  
GP.

PARTICIPANT:  
Say paste patients GP and then pharmacist should be there as well.

INT:  
Umm.

INT:  
OK. And why?

INT:  
Why do you say that?

PARTICIPANT:  
Just because.

PARTICIPANT:  
For like I said before, if we are doing something like deprescribing of medication, I look at it for example and I will see that maybe there's five things that need stopping or five things that needs changing.

PARTICIPANT:  
We still run it through the GP and then the GPU will say OK, I'm happy with this or not happy with this.

PARTICIPANT:  
We have a discussion and then we action it.

INT:  
Umm.

PARTICIPANT:  
So that's why I said in that we the way we work down here in our place is that we, you know, discuss things even if there are things that needs action in are still, you know, make sure that I run it through the GP and then.

PARTICIPANT:  
Actually, so that's why I said pharmacist and the GP.

INT:  
Palms GP.

PARTICIPANT:  
Yeah.

INT:  
OK. Thank you.

INT:  
And when is it or not?

INT:  
When is it not as well appropriate to involve patients?

PARTICIPANT:  
What do you mean when is it not appropriate for patients and what?

INT:  
In those in those deprescribing discussions in primary care.

INT:  
The people living with dementia or mild cognitive impairment.

INT:  
When is it?

INT:  
Are there any occasions when it is appropriate to involve patients or is not appropriate to involve patients in those discussions?

PARTICIPANT:  
On, I mean, sometimes, hey, you have patience that and because we are all humans sometimes when you are having a home visit or having a discussion in the presence of the patient, sometimes they don't hear the word.

PARTICIPANT:  
World dementia.

PARTICIPANT:  
Or don't want to know that what has been diagnosed so you so at that time you have to have that discussion with the career elsewhere.

PARTICIPANT:  
It depends on what it is.

PARTICIPANT:  
If it's entering on discussing the ailment or saying that it has.

PARTICIPANT:  
What's the what?

INT:  
Umm.

INT:  
Umm.

PARTICIPANT:  
Is advanced, for example, that the ailment is advanced, so we don't talk about it in the presence of fashion or when.

PARTICIPANT:  
And sometimes, if you have to, you know, discussing preservation, you just try not to say that.

PARTICIPANT:  
But it's just because we all human.

PARTICIPANT:  
You don't want to station where you say something that upset the patient.

PARTICIPANT:  
It might, you know, accidentally.

PARTICIPANT:  
I don't know if you understand what I'm trying to explain.

INT:  
He's like, yes, yes, I do.

INT:  
The Yeah, the kind of impact of the word for the patient.

INT:  
And the same question in terms of involving informal caregivers, when is it appropriate or not appropriate to involve informal caregivers in those deprescribing discussions?

INT:  
OK, people living with dementia.

PARTICIPANT:  
Umm, I think if you're going to change patients medications, you need to make them aware and in this situation it will be the caregiver that you tell them what's happening.

PARTICIPANT:  
Because if you explain this to the patient, the problem may not remember what you explained.

PARTICIPANT:  
So if I'm changing anything I explained to the caregiver, this is what I'm changing.

PARTICIPANT:  
This is the reasons why and tell them you know it's the symptoms, comes back or what to look out for to let us know and then we'll take it from there.

INT:  
Umm.

PARTICPANT:

So I think in it is appropriate to involve the caregivers where you are changing the medication or deprescribing them until there was a reasons why.

INT:  
I, E and are there any occasions when it's not appropriate to involve the caregivers?

PARTICIPANT:  
No, that I know of.

PARTICIPANT:  
I've never, you know, changed anything without letting the care different.

PARTICIPANT:  
Know what I'm doing?

PARTICIPANT:  
Why I'm doing it?

INT:  
OK.

INT:  
And what would assist engagement with health and social care colleagues to support shared decision making for people, for deprescribing, for people with dementia?

PARTICIPANT:  
What would assist engagement for searching?

PARTICIPANT:  
I think more better communication and I can only give example from round where I I'm based.

INT:  
Umm.

PARTICIPANT:  
We do have regular MDT meetings for any mental health and we talk about any complex cases that needs an action in or.

PARTICIPANT:  
We talk about deprescribing what needs to happen soon, and we involve a wider team of health care professionals, so.

PARTICIPANT:  
I think if I think it will be, communication would help better communication, not that we have issues here.

PARTICIPANT:  
I'm just saying in communication it will be and mutual respect for one another.

INT:  
Mm-hmm.

PARTICIPANT:  
So that will improve that.

INT:  
It's not the communication and respect mutual respect.

INT:  
Yeah.

PARTICIPANT:  
Yes.

INT:  
OK.

INT:  
And what would assist engagement or involvement of patients living with dementia?

INT:  
Mild cognitive impairment and all their informal caregivers in the deprescribing process.

PARTICIPANT:  
Knowing the.

PARTICIPANT:  
That they can always, you know, like when you speak to a patient, you safety net.

INT:  
Mm-hmm.

INT:  
Umm.

PARTICIPANT:  
Knowing that they can always call back if they have questions or any problems, is it what's the word when a patients, those that they can always call back, if any problem for example and I dementia team they have a due call that case it case passing per patient for a patient.

INT:  
Umm.

PARTICIPANT:  
So every patient has an assigned dementia and specialist for them that they can always give a call during working hours if they need anything or any assistance.

INT:  
OK.

INT:  
What?

INT:  
What and what role does that?

INT:  
That person?

INT:  
What are they from a particular professional background that the I stopped?

INT:  
Mm-hmm.

PARTICIPANT:  
And we just, we called them like the dementia team in our end and they have, you know, the carers do have their number if need be, but that, you know, we didn't walking hours, they can always call.

PARTICIPANT:  
So that's just how what we didn't down at their end.

INT:  
OK.

INT:  
Thank you.

PARTICIPANT:  
I.

INT:  
And that's like case specialist from the dementia teams, is that right?

PARTICIPANT:  
Is that is that?

INT:  
OK. PARTICIPANT:  
Problem.

PARTICIPANT:  
Yes, it's.

PARTICIPANT:  
Well, being dementia coach.

INT:  
Well, being dementia couch.

PARTICIPANT:  
Yeah.

INT:  
OK.

INT:  
Thank you.

INT:  
And every patient with dementia has.

INT:  
Umm.

PARTICIPANT:  
So OK, our patience is assigned, you know to somebody, I mean, you know their carers or whoever and.

INT:  
OK.

PARTICIPANT:  
Yeah, they're walking up PCN.

PARTICIPANT:  
Yeah.

INT:  
And did they work within the primary care, the wellbeing? Yeah.

PARTICIPANT:  
And they're part of our dementia team in our PCN.

INT:  
Sorry.

INT:  
OK.

PARTICIPANT:  
Yeah.

INT:  
Thank you.

PARTICIPANT:  
So he's wellbeing coach?

PARTICIPANT:  
Yeah.

PARTICIPANT:  
No welcome.

INT:  
OK.

INT:  
And what would facilitate good communication with patients living with dementia or mild cognitive impairment and all their informal caregivers in the deprescribing process?

PARTICIPANT:  
So I say that again.

INT:  
Yes, sorry.

INT:  
So this ones about good communication.

PARTICIPANT:  
Blue.

INT:  
So what would facilitate good communication with patients living with dementia or mild cognitive impairment and or their informal caregivers in the deprescribing process?

PARTICIPANT:  
I think I've mentioned this before, and so when you say good communication, it's just and then the window there, they can always come, come back or ask questions if they don't understand.

PARTICIPANT:  
And before I change anything, I explain what is happening, why we are changing the medication, I mean not change deprescribing.

INT:  
Umm.

PARTICIPANT:  
It's the word.

PARTICIPANT:  
So why we're deprescribing this medications and the reasons and the effects that it can have on them, things like that.

PARTICIPANT:  
So I think.

PARTICIPANT:  
Is that up?

PARTICIPANT:  
Is that the right word?

PARTICIPANT:  
Open door policy.

INT:  
Mm-hmm.

PARTICIPANT:  
Hold that.

PARTICIPANT:  
So it's just them knowing that they can always call back because you know, if you caring for dementia patients, you need all the help that you can get in, especially when it comes to the healthcare professionals knowing that they're there.

240  
INT:  
Umm.

PARTICIPANT:  
If I don't understand anything, or anything about the medications or the medication that is having a side effects or things like that, they can always call colours and we explain again.

INT:  
Mm-hmm.

PARTICIPANT:  
Hey, why?

PARTICIPANT:  
So I think that's what I can say.

INT:  
Thank you.

PARTICIPANT:  
It's.

INT:  
And what?

INT:  
What language should be used in communicating information about medications with people with dementia and their informal caregivers?

PARTICIPANT:  
Very simple layman's language.

PARTICIPANT:  
So make it very clear.

PARTICIPANT:  
Very easy to understand the use technical jargon or medical terms because they might not understand, so something very simple and clear.

PARTICIPANT:  
For example, just give an example if someone is on, I don't know and.

PARTICIPANT:  
Clopidogrel you know clopidogrel? Yeah.

PARTICIPANT:  
Sorry.

INT:  
I don't know.

INT:  
No, no, no, sorry.

PARTICIPANT:  
Said the dog is like an anti platelet, is a blood thinner.

PARTICIPANT:  
For example, you can say ohh they might ask, might ask why am I?

PARTICIPANT:  
Why is the patient on this?

PARTICIPANT:  
What does he do rather than saying, oh is an antiplatelet and these are some days and that you're confusing them.

PARTICIPANT:  
But if you say to them ohh, this actually helps to make your blood less sticky.

INT:  
Mm-hmm.

PARTICIPANT:  
They understand that better because it thins your blood and because of this.

PARTICIPANT:  
That's why it prevents you from getting this and that if I hope I'm making sense, yeah.

INT:  
Yeah, we are.

INT:  
Yeah.

INT:  
So it comes back to that what you said about very clear and simple language.

INT:  
Yeah.

PARTICIPANT:  
Yes. Ohh.

INT:  
Yeah.

INT:  
Thank you and.   
INT:  
Umm, how do you feel about engaging patients with dementia?

INT:  
Mild cognitive impairment in shared decision making as part of the deprescribing process.

PARTICIPANT:  
Yes, I mean you can invoke.

In involve them, like I said earlier on that.

PARTICIPANT:  
Small dementia.

PARTICIPANT:  
They still have a capacity, some sort of capacity, so.

They can be involved in their care.

PARTICIPANT:  
Well, it's just that we also need to be aware that because they have, you know, dementia, some not everything.

PARTICIPANT:  
They wouldn't remember everything.

PARTICIPANT:  
So you still need the carer or power of attorney if someone that's got the power of attorney, do you also be there so that they will get understand the whole the full picture?

INT:  
OK.

PARTICIPANT:  
I don't know if I'm making sense.

INT:  
Yes, yes, yes, thank you.

INT:  
And what would help facilitate their involvement in shared decision making?

INT:  
So you've mentioned the having the care or the power of attorney.

INT:  
Anything else that would help?

PARTICIPANT:  
I mean the patient is there anyway, is that you mean anything else and?

INT:  
Yeah.

INT:  
Yeah, to help the about engaging patients with dementia, part of the shared decision making, if there's anything else that will help that.

PARTICIPANT:  
Umm. Mean.

PARTICIPANT:  
I'm back and think of probably there is maybe sharing information in written language or something like that, but I think.

INT:  
Umm.

PARTICIPANT:  
And.

INT:  
OK.

INT:  
Mm-hmm.

PARTICIPANT:  
I think those are the two things I can just think of and whatever information that you're sharing with them, make sure that it's clear if we if you give it to the patient, make sure it's clear to them.

PARTICIPANT:  
Simple.

PARTICIPANT:  
And because you know any stage or me?

PARTICIPANT:  
Mild dementia.

INT:  
Yeah.

PARTICIPANT:  
Know symptoms are mild and they're not always noticeable, but like I said, they have capacity as well for the may not remember everything, so need to skip the care.

INT:  
OK.

INT:  
And what are the barriers to engaging patients with dementia in shared decision making as part of the deprescribing process?

PARTICIPANT:  
Jim.

PARTICIPANT:  
Umm.

PARTICIPANT:  
So it could be.

PARTICIPANT:  
Maybe not understanding everything.

INT:  
Umm.

PARTICIPANT:  
Umm.

PARTICIPANT:  
And like I said, sometimes you know when some patients don't want to hear the word dementia.

PARTICIPANT:  
And then in my, you know, make them more.

PARTICIPANT:  
Make them not want to engage.

INT:  
Umm.

PARTICIPANT:  
If you get what I mean. Umm.

PARTICIPANT:  
And that's all I can think of in my head at the moment.

INT:  
Thank you.

INT:  
Thank you.

INT:  
And how do you feel about engaging informal caregivers of patients with dementia or mild cognitive impairment in shared decision making as part of the deprescribing process?

PARTICIPANT:  
He read that again, please.

INT:  
Yes, sorry.

INT:  
So it's the same question, but now for informal caregivers.

PARTICIPANT:  
Hmm.

INT:  
So how do you feel about engaging informal caregivers of patients with dementia or mild cognitive impairment in shared decision making as part of the deprescribing process?

PARTICIPANT:  
And I feel I think is a good thing to involve the caregivers because at the end of the day, we said shared decision making in deprescribing.

PARTICIPANT:  
Let's say for instance, if we are discussing patient X for example, and then we've said these are the things that would that we would do to deprescribe their medications and.

PARTICIPANT:  
Get having the keg, Cara or caregiver involved.

PARTICIPANT:  
Also make things easier, cause whatever they're not, they're not clear on.

PARTICIPANT:  
They can always ask the questions there and also any concerns that they have and they can voice it there as well.

INT:  
Umm.

PARTICIPANT:  
So and I think it is a good thing to get them for them to be involved in.

PARTICIPANT:  
Obviously we just need to be mindful of, you know, the language to use, making sure that it's not too.

PARTICIPANT:  
It's not too medical.

INT:  
OK.

INT:  
And what would help facilitate their involvement in shared decision making?

INT:  
You've just mentioned about the language.

INT:  
Maybe it's something that would help.

PARTICIPANT:  
Oops. Umm.

INT:  
Is there anything else?

PARTICIPANT:  
And language communication and.

PARTICIPANT:  
I think communication.

INT:  
Umm.

PARTICIPANT:  
Giving them also because there's something I forgot to mention and you know the care is sometimes they do get carers stress knowing that you know if that happens that they can always come to us to get some rest bites even if it's once a week, a few hours a week and just I think from my experience if they know that we're here and we're happy to help and they can always reach out it works and it has always worked for us.

PARTICIPANT:  
So

PARTICIPANT:  
That's it.

INT:  
Yeah.

INT:  
And what kind of help would they would they get with that?

PARTICIPANT:  
They get respite.

INT:  
Umm.

PARTICIPANT:  
So

PARTICIPANT:  
So they get like a few hours a week where they can go hang out with their friends or grab a coffee, and someone can stay with the patient for that our maybe get them another care at to stay with the patient or take the patient to Sunshine Club.

PARTICIPANT:  
So things like that so that they can have some relief for that few hours.

INT:  
Umm OK, thank you.

PARTICIPANT:  
Yeah, but yeah, it's fine.

INT:  
Yeah.

INT:  
And on the other hand, what are the barriers to informal caregivers engaging informal caregivers of   
PARTICIPANT:  
Sometimes they just don't want to communicate just and you could, you know, try to engage many times.

INT:  
Umm.

INT:  
Umm.

PARTICIPANT:  
So you have to make you know more effort to, you know visit.

PARTICIPANT:  
Make sure patient is OK make sure things are.

INT:  
Mm-hmm.

PARTICIPANT:  
Working as a shade and then.

PARTICIPANT:  
Sometimes.

PARTICIPANT:  
Is easier for them, like face to face appointment rather than telephone sometimes.

INT:  
Hmm.

PARTICIPANT:  
And if they don't have the means of, is it mode of transport to come in?

INT:  
Umm.

PARTICIPANT:  
Then that also is a barrier, so we have to arrange to go visit them instead, and sometimes in unable to go get the patients medication from the pharmacy then we have to arrange for the leave for that to be delivered to them.

PARTICIPANT:  
So there are few.

PARTICIPANT:  
And you know things that can.

PARTICIPANT:  
See what's the what?

PARTICIPANT:  
The hand which is the engagement.

INT:  
Umm.

PARTICIPANT:  
Of the care of.

INT:  
OK.

INT:  
Thank you.

INT:  
And what tools?

INT:  
What tools or resources are needed to facilitate shared decision making in relation to deprescribing for patients living with dementia or mild cognitive impairment please?

PARTICIPANT:  
What does a facilitated?

INT:  
Yeah, tools or resources are needed to help those shared decision making in relation to deprescribing patients living with dementia.

INT:  
Show.

PARTICIPANT:  
OK. Uh.

PARTICIPANT:  
Obviously, when you come to shared decision making, you responsible this making decision with the patient or the carer for their health so.

PARTICIPANT:  
Communication again.

INT:  
Umm.

INT:  
Umm.

PARTICIPANT:  
Making sure that what you're explaining is very clear, because if the carer slash patient understands clearly what you're explaining to them and the decision that you ask and table into them to say this is what I want to do, it will help them to make those decisions together with you

PARTICIPANT:  
So I think and communication.

INT:  
Mm-hmm.

PARTICIPANT:  
Helps and then?

INT:  
Umm.

PARTICIPANT:  
Sometimes a even if it's verbal, sometimes it's verbal, sometimes it's written sometimes.

PARTICIPANT:  
And even with when it's written, it has to be clear as well and give them the opportunity to, I reply or answer back.

INT:  
Mm-hmm.

PARTICIPANT:  
But I think that good communication is a good tool.

INT:  
OK.

INT:  
Thank you.

INT:  
And how best would patients living with dementia or mild cognitive impairment and their informal caregivers be supported during the deprescribing process?

PARTICIPANT:  
Scribing process.

INT:  
Umm.

PARTICIPANT:  
I mean what I like I said before, what I do is once I've liaise with the higher clinician, which is a GP on what I want to deprescribe, for example, then I liaise with the camera of the patient with dementia and then we just explain.

PARTICIPANT:  
What I'm doing?

PARTICIPANT:  
Why we're doing that, and let's say because you said what tool isn't it?

INT:  
Umm yes, this this question.

PARTICIPANT:  
Umm deprescribing?

INT:  
Yeah, I mean this this question was more about the kind of, umm, support for supporting patients living with dementia as part of the deprescribing process, yeah.

PARTICIPANT:  
So I mean, after discussing with the camera, I always lease, we are dementia team as well just to make them aware what we're doing and then they do when they do home visit, they check in, make sure that things are OK and then if anything needs reinforcing, they can reinforce that in terms of what it has been described, make sure that patients and their carers are tearing to the advice that's been offered to them.

INT:  
Mm-hmm.

PARTICIPANT:  
And if anything that needs uh pharmacy team to action, the dementia team will just let us know.

INT:  
OK.

PARTICIPANT:  
But basically, that's just what we do.

INT:  
OK.

INT:  
Thank you.

INT:  
And how would best three, how best would patients living with dementia or mild cognitive impairment be followed up as part of the deprescribing process names?

INT:  
Umm.

PARTICIPANT:  
And it depends on the medication that it's been deep prescribed so.

PARTICIPANT:  
If you are deprescribing something like an antipsychotic.

PARTICIPANT:  
Thank you.

INT:  
Umm.

PARTICIPANT:  
Follow up every two weeks, at least until the medication is tapered and stopped.

PARTICIPANT:  
As you mean that the DPS symptoms is resolved and then after that was the tapering and medication has been stopped.

PARTICIPANT:  
You also follow up again at week two and I follow up at Week 4.

INT:  
Umm.

INT:  
Mm-hmm.

INT:  
Mm-hmm.

PARTICIPANT:  
This is to make sure that the symptoms is not there, and then what I do again is follow up again two months later and if everything is OK, I'll leave it be.

INT:  
Umm.

PARTICIPANT:  
And then obviously we safety Nets and tell them we contact if anything changes or any symptoms that yes, you let us know and they always do.

INT:  
Umm.

PARTICIPANT:  
If anything changes it, just let us know and we just action accordingly.

INT:  
OK.

INT:  
Thank you.

INT:  
And does that depend on each on each medication?

INT:  
How often they would be reviewed?

PARTICIPANT:  
So that depends.

PARTICIPANT:  
That's why I said it depends on the type of medication we deprescribing and.

PARTICIPANT:  
That will also tell did that medication will also tell us how often we follow up when we're deep prescribing that medication.

INT:  
Thank you.

PARTICIPANT:  
And yes.

INT:  
OK.

INT:  
And who should be following up patients please?

PARTICIPANT:  
The patients are being we're deprescribing their medication.

INT:  
Yes, yes.

INT:  
Yeah, yeah.

PARTICIPANT:  
I mean, if I'm deprescribing the patients medication, I'm the person that will be following up until the medication is been, you know, deep prescribed.

INT:  
Umm.

PARTICIPANT:  
And that's it.

PARTICIPANT:  
So I think that.

PARTICIPANT:  
Whoever that is, deprescribing anything should follow up the patients.

PARTICIPANT:  
So if I'm deprescribing it, I follow up the pharmacist.

PARTICIPANT:  
If another clinician, that and the.

PARTICIPANT:  
Is within their scope to deprescribe.

PARTICIPANT:  
Medication is doing that.

INT:  
OK.

PARTICIPANT:  
They should be following up, but sometimes you know.

PARTICIPANT:  
Some clinicians may start deprescribing and then ask the pharmacy team to, you know, follow up and oversee the deprescribing, which we do all the time.

INT:  
OK.

PARTICIPANT:  
Not a problem, so yeah.

INT:  
Thank you.

PARTICIPANT:  
So, right.

INT:  
And what are the potential facilitators to integrating shared decision making in relation to deprescribing medication for patients with dementia into your everyday practice?

PARTICIPANT:  
Such a facilitators.

INT:  
Yeah.

PARTICIPANT:  
Do you mean the people that that can?

INT:  
Umm, who?

PARTICIPANT:  
It.

INT:  
The things that might help to integrating it in shared decision making into your everyday practice in relation to deprescribing for patients with dementia.

INT:  
So the things that might help that.

PARTICIPANT:  
Umm.

PARTICIPANT:  
OK.

PARTICIPANT:  
I mean one thing though we do is to from the run sets on which is got dementia for example, and then a.

INT:  
Umm.

INT:  
OK.

PARTICIPANT:  
We find that if, once we find the list of the patients that have called dementia and we liaise with my other colleagues and there are, you know, nurses that just do dementia review for us and we do that, you know.

INT:  
Thank you.

PARTICIPANT:  
Here on making sure that the review is done and they have a.

.60  
PARTICIPANT:  
What is that?

PARTICIPANT:  
OK, something care.

PARTICIPANT:  
Forgot what it's called.

INT:  
You.

PARTICIPANT:  
But if I remember it, I'll tell you.

INT:  
Umm.

PARTICIPANT:  
So we make sure that they have that in place after, you know, once the review is done.

INT:  
OK, Kaplan.

PARTICIPANT:  
Sorry, that's it.

PARTICIPANT:  
That's, that's careful.

INT:  
OH was it OK?

PARTICIPANT:  
My something care you remember?

PARTICIPANT:  
Yeah.

INT:  
Umm.

PARTICIPANT:  
So they make sure that they have a cat plan in place and was the review is done.

PARTICIPANT:  
If there's anything regards the medication, so say for instance because in our box here, if the patient is doing medication review, it will flag off, then the nurse will years with my team there we organizing medication review for the patient and then take it from there.

PARTICIPANT:  
Ohh so and apart from that the.

INT:  
Umm.

PARTICIPANT:  
We already have the dementia team in place that also, you know, work from their own angle.

PARTICIPANT:  
So if say for instance I speak to someone and they said Ohh, I think I'm forgetting things, I can't remember basic things.

PARTICIPANT:  
I mean it's we are dementia team to go out and do a memory test for the patient just to make sure things are OK and if not, they just let us know.

PARTICIPANT:  
We'll take it from there.

PARTICIPANT:  
So I think in terms of what you said, OK, how will we put things in place?

INT:  
And on the other hand, what are the potential barriers to integrating shared decision making in relation to deprescribing medication for patients with dementia into your everyday practice?

INT:  
So what are the things that are difficult or challenging about that?

PARTICIPANT:  
For communication.

INT:  
I mean, OK, communication.

PARTICIPANT:  
Welcome me vacation.

PARTICIPANT:  
And umm, I mean, sometimes poor and fishing engagement or poor access to health care. Ohh.

PARTICIPANT:  
And sometimes.

PARTICIPANT:  
And sometimes I forgot and sometimes maybe low staff as well can.

PARTICIPANT:  
Effects and integrating things like that.

INT:  
She.

PARTICIPANT:  
Sorry.

INT:  
And yeah, sorry I just said thank you.

INT:  
And can you identify any training or educational needs for you or your colleagues to enable you to safely stop unnecessary medications for someone with dementia or mild cognitive impairment?

PARTICIPANT:  
Yeah.

INT:  
Umm.

PARTICIPANT:  
There's training for deprescribing on CPE.

PARTICIPANT:  
There are polypharmacy and AHSN polypharmacy trainings.

PARTICIPANT:  
And then there are also deprescribing courses that you can attend on PCP and it is called the Center for the Pharmacy Postgraduate education.

INT:  
OK.

INT:  
And the other one, PCP, a IMS it.

PARTICIPANT:  
Yeah, PCP A and that is the primary care.

PARTICIPANT:  
Primary care from their sociation.

INT:  
OK.

INT:  
Yep, I got that one.

PARTICIPANT:  
And also I did say AHSN you know that one?

PARTICIPANT:  
Yeah, yeah, yes.

INT:  
Umm. Yeah, OK. INT:  
OK.

INT:  
Thank you.

INT:  
And any other training or educational needs.

PARTICIPANT:  
We're Augusta dementia.

INT:  
Yeah, for.

INT:  
For disabling to safely stop on this very medication for someone with dementia, any other needs that are maybe not being met or.

PARTICIPANT:  
Not really, because I mean, we work so well done.

PARTICIPANT:  
Our end here so it and in general I'm thinking.

PARTICIPANT:  
Not really.

PARTICIPANT:  
I think if you.

PARTICIPANT:  
Attend those courses if you have an, or if you're not willing to fix with regards to deprescribing or only pharmacy to attend this courses, I think you should be OK with deprescribing any medication meeting.

INT:  
OK.

INT:  
Thank you.

INT:  
And is there anything else that you want to tell me or anything you wish to add to what you've already said today?

INT:  
Yes.

PARTICIPANT:  
And I think some of the questions that are probably didn't answer it properly cause I, but I hope I answered in your questions to the best of my ability.

INT:  
Well, we've come to the end of the interview now, so thank you very, very much.