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

**Transcript**

**HP01**

INT:  
So today I'm undertaking the interview on the 4th of July. So firstly I just like you to tell me about the care you provide to people with dementia or mild cognitive impairment, please.

HP01  
OK. And so I will know might be providing other home visits or visits to the surgery or telephone triage and treat treatment which is in involves any sort of like a presentation with any minor problems to more complex illnesses. Their care involves assessing treating and referring those patients…They require goes.. What's the wide range of things from like a simple chest infection or urine infection, or any sort of like simple infection to antibiotics to some more serious like to like threatening conditions. Uh to like admission to hospital or any admission avoidance to the sort of like end of life care I will do with that. It's kind of a patient cohort who makes sense.

INT:  
Thank you. And is that both for people with living with dementia and mild cognitive impairment?

HP01  
Yes. So I would come across either of those people. I don't specifically just work with other people with dementia alone. I do work from. I do see people from like birth to death, so it's a bit of a wide range of a patients and through most of them are again are out with the dementia. I'm coming to impairment of some sort and it's like but that whenever they present to the GP practice, they can see me for a variety of reasons as I said before.

INT:  
OK. And how much of your workload is providing care to people with dementia or mild cognitive impairment?

HP01  
So it's probably like 20 to 30% of the clinical mechanical practice probably that it is difficult to say exactly. I haven't got a figure about which is probably a good 20/30% of at the very least.

INT:  
20 to 30% at the very least.

INT:  
Thank you. How many of those people are taking multiple medications?

HP01  
I would say about 95% of them.

INT:  
OK.

HP01  
Yeah.

INT:  
And is that both dementia and mild cognitive impairment?

INT:  
OK. And what involvement do you have in their medication management?

HP01  
Uh, that I would say that there's a push and a focus on the deprescribing, or at least especially with the patient, that trail and the struggling to understand what they're taking on, what they're taking. And there's always a bit of a push to try to reduce the amount of medication that can be harmful.

HP01  
So I would say of. That we do have an hour surgery, some pharmacies, they do like some medicine reviews. So that entirely focus on the medication as such, but from time to time when you come across patients with but polypharmacy or search with the dementia or some cognitive impairment, I would always have a look toward their own.

HP01  
And there's some drugs that obviously harmful or not necessary. I would instigate at least two staff thinking about stopping them and the issues always finding the time to do that because sometimes you focus on dealing with acute problem and you don't have necessarily the time to do that. But if you sometimes that you wanna make the time to do that and then stop some harmful drugs that they can. So hopefully I have a bit of an impact on the patient life. Makes sense.

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

HP01  
I think from experience is way too much medications that people are on, especially with dementia, is difficult for them to advocate for themselves and to say you wanna stop stuff or I want to take something for whatever reason. So I think that there's a really a is a bit of an area where there's a huge gap on those patients cannot ask for help as in like I wanna come off some SSRI's or some helpful medication or OK because they said they gonna starting or some aspirin for like 30/40? years or somehow antihypertensive. And then sometimes it's the surgeries for failure not to recognize that those people don't need to be on them. So it's like a systematic way to sort of stop those things.

HP01  
Umm, I think sadly. Also, there's very little. There's not much research about there about deprescribing again, and that's and that's my opinion that obviously there's lots of research about drugs that gets sold, but it's very little research about stopping drugs because again, it's not very profitable. So not many people do a lot of research on it. I think that they this is a bit need.

HP01  
There's a need to get some research backing again the prescribing protocols and evidence behind it. So then people will actually be more prompted to do it, I think.

INT:  
Thank you. And any advantages of deprescribing of inappropriate medication among people living with dementia or mild cognitive impairment?

HP01  
Yeah, most will be like reducing, like serotonin syndromes, reducing advanced drug reaction and unnecessary kidney failures. The hyperkalaemia.

HP01  
So. So on a lots of hospital admissions are because of a there's quite a few hospital admission because we got patients taking 10 different drugs and they're becoming more and more. Dehydrated, for whatever reason they're having falls, breaking their hips.. they don't need so that there's, you know, there's a huge list of benefits from stopping things that are not needed.

INT:  
Thank you. And what about disadvantages regarding deprescribing? Are there any?

HP01  
Yeah, it's disadvantages. It's difficult for you to monitor if you actually done, you stop the right meds. So if you wanna stop some medication and perhaps something with them. Like a H2 antagonist for like indigestion. Or so they've been talking for years and it's giving them low sodium. And is it difficult for the patient itself to come and tell you I'm now- Stop them suffering and I think stopping that has a stopping make made things worse.

HP01  
So I think it's the feedback from the patient whether you know they found the had a benefit from stopping the drug or not.

HP01  
But that's not the one and two you sometimes you know you could stop drugs. So you stop or you can stop and anticoagulant because you didn't that person to be too frail to, you know, pull it to need that. And that person can have a stroke or a side effect when you stop the drug. That's kind of like a risk.

INT:  
OK.

HP01  
Again, it's a risk and benefit for the balance, but sometimes you can get you get the side effect.

HP01  
You know you don't want impacting overall it's again, you have to balance things out and you accept it. If you know worst case scenario that happens that the complication happens, that's it's reasonable to take that risk.

INT:  
OK.

INT:  
Thank you. And how could some of those challenges you mentioned be resolved?

HP01  
OK.

HP01  
I think I come. a systematic approach or a. It should be like something flagging up on the system to say this person. It's a umm he's got some criteria to be triggered, so those medication after certain age and needs to be reviewed. Why are you giving this drug to this patient? And you should consider stopping things. And I got this should be done by somebody who's actually been trained to deprescribe because I think not all of the clinicians are well. We should be stopping.

HP01  
Always stopping it and there's people have different like prescribing and people think like, you know, they're been on for 40 years. Just leave them on. It's not gonna harm them. And you know other conditions of being the more younger one. That'll be more like proactive in thinking of, you know, we should not keep people on these drugs for so long, especially if you try to stop the reduced to the, to the minimum, what they need, I think it's all about the education really and having the right person who's doing the right job.

INT:  
OK. Thank you.

HP01  
Thanks.

INT:  
So you mentioned that the systematic approach and the education and the and the right person there as well.

HP01  
Yep.

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

HP01  
OK.

HP01  
Uh personally. Ohh I'll be looking at.

HP01  
Uh. This is a bit of debate, but one of the things I'll be looking at is uh statins, antihypertensives, and painkillers like opioids or any antidepressants. Also that I wouldn't say I'm confident about at this. Certainly think about stopping those. Any sort of like a?

HP01  
Medication that increase the let's any set of tones of the risk syndrome. Those are all drugs that you should be thinking that we need to keep those or not and just take some time to go to the notes and have a look.

HP01  
Why are they on this medication? For one, was started. Do we need to have this still or no? And is difficult without, you know, the patient telling you they still having symptoms or if this is causing the problem or not. So that that's why I think the difficulty is in stopping things because you just have to like decide whether you know it's just gonna stop it and then and then may have problems after that or not. It's just a bit of a again, a bit of a risk, but quite often I've been using the. There's a serotonin calculator.

INT:  
Umm.

HP01  
You can calculate the serotonin syndrome risk and it tells you which drugs are the most high, high risk and you can only go with those first. Although I don't always remember which one that they are just going to go to the calculator and take it from there sometimes.

INT:  
OK.And then any other reasons why those drugs?

HP01  
I think that the most the one that the most prescribed and the most harmful as well, I think especially people with dementia were certain syndrome and increased confusion or any drugs that increase the risk of falls

HP01  
Umm, they're all drugs that sometimes unnecessary. Especially like antihypertensive as well.

HP01  
Yes, you'll you. You worry about her after certain age and after, especially with the dementia sometimes you I would be accepting like a higher pressure other than be worried about them having or the starting drops and then falling and breaking the hips and then having like a 30% mortality risk when they go to hospital.

HP01  
Umm that answer your question.

INT:  
Yes.

INT:  
Thank you. And what would encourage you to support reducing or stopping the medication?

HP01  
I would say, well, number one, patient quality of life and patient outcomes.

HP01  
So doing so, the more you stop, the more harmful drugs you stop the less harm the patient will have. And again, those are patients that cannot really advocate for themselves and two would also be like, I think there's an economic side of things. So will be like reducing unnecessary spending on drugs on people that actually don't need them. Stopping this the main thing will be patient safety and the second one will be also, you know, stopping something which is not necessary and then that money can be spent elsewhere for the those drugs, those are the main thing.

INT:  
Main things.

HP01  
What would I can think of? Yeah.

INT:  
OK. Thank you. And what medications would you be reluctant to deprescribe and why?

HP01  
OK. The more reluctant one, the one would be more reluctant to deprescribe would be any DOAC anticoagulants.

HP01  
Unless there's, like, there's been, like, serious, like, uh, multiple like head injuries. Like I think you need to about like 15 or 20 in one year. OK. That's one. Any cardio protective meds as in like the blockers or meds to stop arrhythmias of those are quite warning. This is the prescribed medications for like a COPD to manage, like chronic illnesses as a of cardiac or. What lung pathology?

INT:  
Umm.

HP01  
Chronic ones I will be inclined not to stop them because as the soon the moment you stop them, you can't read it. And nasty side effects and hard to take your medication.

HP01  
Umm. Again, you stopped. You stopped and that person starts to have the I've exacerbation of that and then they are not well at all. So I think any medicines that give patients a comfort, a relief on the illness is a thing that should be something that look into carrying on as long as I can't go see you there. Side effects.

INT:  
OK. Thank you.

HP01  
Thanks.

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

HP01  
Uh, I can, as we said before, there should be a. Just like a list of patients on the on the GP surgeries they have flagged up and that each year they need to have the medication review though at least like every three or four years.

HP01  
So you have like a cohort like 1000 patients, those thousand patients. So the meds reviewed say and after that, after three every two or three years have constantly have those meds reviewed, but that should be done by somebody who's got a background in pharmacology or some word that is given him enough. Have enough knowledge for them to know what needs to be stopped. Like what kind of be stopped and you know, do we need to stop? Do we review it or do we just stop it? It's quite, I think it can be quite a risky decision that that's why most people sometimes they just people don't bother deprescribing because it's easier just to leave people what their own and don't worry about what happens.

HP01:  
But I think again, there's a duty of care by, you know, doing no harm by action or inaction. So I think they need to be taken care of. That something needs to be done and I think again, a systematic approach. Some said sort of rules or I'm not sure if there's any guidance as from now. So any like governing bodies or CCG to say, you know, you need to review those special medications every so often. Uh, yeah, that there are some. Some guidance of a practice, but again I'm not too familiar with them and perhaps some not. I know we have a we do a person have a pharmacy team that does some? There's some medication review, some not too sure what they do.

INT:  
OK.

HP01  
If they have a list of patient with the that review like that or not is, is that answer your question more or less, yeah, yeah.

INT:  
So again, that, that, that systematic approach as well and needing familiarity with those with those kind of guidelines. And please describe your experience of having deprescribing discussions with people living with dementia or mild cognitive impairment or their informal caregivers.

HP01  
Yeah. I think that can be quite challenging, as in obviously is the person's got to be the … You can we have the conversation with them. You have the conversation with the carers and I think the carers are quite understanding of things. They are.

INT:  
Mm-hmm.

HP01  
They just want what's best for their mom or dad or so on, and they tend to trust you or, you know, they understand the, you know, they are very frail and we just focus on what it's best for them rather than, you know, the key than just everything. Because those things can aggravate you, sometimes can have a chat with the patient about it, and I think most patients are quite happy to say yes, I'm happy to stop that. If you have some understanding what's going on again, you still you still required to have conversation with next of kin or whoever's like legally responsible for the medical decision. But uh, it's about it's a difficult conversation. It one of the issues that it takes time and from experience quite often like in hospital, in GP search is often people just you just stop things and tell the patient or the next of kin.

HP01  
We stop this. You don't need it. Rather than having like an in-depth conversation tool, we think we should stop this. What you think and so on, so that that's my experience about really.

INT:  
OK.

INT:  
And you, you mentioned there in in hospital as well.

HP01  
Hmm yeah.

INT:  
Do you like anything more about that?

HP01  
Uh, but I I think work like for over four years in a hospital prior to primary care and the experience there, specially people, dementia or cognitive impairment, is that there's a quite the fairly good for from the sort of like the medical team to stop things. They're not necessary, but the way it gets done is like the consult the technician just comes around and just cross things off and said let's stop this.

HP01  
They probably don't need it. Rather than actually I, you know, having a chat with the patient and so on it, it gets more. I think this is a bit more of a quick approach in hospital and sometimes there's no from experience, there's not much time to discuss. Was like, you know, if you're a, you're doing a formal GP surgery, you got the pharmacist. Just go like 20-30 minutes allocated to do that systematically. That's different. Yeah, this happens by. It happens on, on a base of somebody's really poorly they're trying to make them better, to send them home and at the same time you try to stop rather than not necessary.

INT:  
OK.

HP01  
That's why I've experienced.

INT:  
Thank you.

HP01  
Thanks.

HP01  
Umm.

INT:  
And those experiences you've had of, of having deprescribing discussions with people, with living with dementia or mild cognitive impairment or their informal caregivers. What's worked well about those discussions? Anything you've observed.

HP01  
No, I think it's always works well because the I mean the family loop perceived that you you're trying to do what's best for them and you know trying to sugar coat things it I think they are appreciated.

HP01  
It's easier just to continue things and not to change anything. We're trying to make a change for the for the better to reduce the amount of tablets. I think whenever you talk with families, they all patient, they will say, oh, I'm taking too many medications and you go like, well, I agree with you and I think we should stop some with them. What do you think they always like? Quite happy to reduce the amount of drugs they take and also because they quite often they are. I mean the question with dementia, they get their drugs normally given by someone, but the there's always deserve, you know, the it's not a. It's difficult to keep a good photo like compliance of somebody who's taking, like too many drugs. I think I found it that the patient just stop this thing. I don't want it and the carers that you know, they say, OK, if you don't want it, that's fine. You like? So having less tablets might be that the patient actually just enjoys that time more and just takes the couple tablets.

HP01  
Then we'll need to take rather than things like upset about having to take 100 tablets.

INT:  
Thank you.

HP01  
Thanks.

INT:  
And that that moves me on to what challenges have you encountered and having those discussions?

0:23:57.580 --> 0:23:57.770  
HP01  
Yeah. Ignorance, mainly so people. I just don't want to hear your point to just go like, now that I've taken it for my mom's. Taken the for 20 years, she needs it and no wanted to listen to what you got to say? I think that the, I mean it's kind of like a patient choice, some more. Uh, there's a conversation. How with them? But maybe very rarely people, they say no. Uh, it's just the changes, I guess, like a relatives are just sometimes it can be unhappy about what you're trying to do. I think you're trying to, you know, like send them off by stopping things, but you try to explain this is actually for the best. But no, no.

HP01  
Often because very, very well is perceived like that. But I think it can happen. Some people can be challenging, but I think as long as you can reason with them, you can explain them. And show them. You know what? What are you doing? That what the side effects of this can be, and normally people tend to settle if any show you what, I'm happy with what you're trying to do.

INT:  
OK. And anything that would help facilitate those conversations.

HP01  
So. Thats supposed time and the right environment...It make a difference. You know, doing it face to face or like we just wanna set appointment to say like we're gonna call you this time to discuss these. That helps.

INT:  
The time and time and place there and.

HP01  
And sometimes, like it's nice to have like a figure or like a number to give them to say like the this this chance of that patient having a side effect and the some numbers, some research, some statistics. I think I find it helps, but I don't often I struggled to find anything like that. Perhaps I'm not. don't know what to look for. Somehow evidence.

INT:  
OK, so having that that the statistics and evidence say mentioned as well, yeah. And 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?

HP01  
I think surely a GP.

0:26:33.990 --> 0:26:34.640  
HP01  
OK.

HP01  
I will say clinical pharmacist so pharmacist that undertake. Yeah, uh, additional training. I think they're quite the right person to do that, and I think there's like a bunch of people like a transportations like myself that they do work difficulty with frail people. So like I would say, I frailty practitioners and they see the majority of the elderly fellow people that those will be I think the right people to do that.

INT:  
OK.

HP01  
I'll probably I'll stop that I think.

INT:  
OK. And all. Are there any professional groups who?

INT:  
Who should not be involved, do you think?

HP01  
Umm. So I just think as long as you have a anyone who's an independent prescriber, umm, I think they should, they should be involved with those things because as long as if you're prescribing, you should be also held accountable for deprescribing given the appropriate training. So as long as you are a medical prescriber, unknown medical prescriber independent, I think you should be going forward to that.

INT:  
OK. And who is best placed to lead the discussion?

HP01  
So say that again.

INT:  
Sorry, who is best placed to lead the discussion?

HP01  
sounds kind of the same answer, a question that you just asked me before, so I'll probably I'll again, I'll say that the GP, the pharmacies, again I can't think of one that I will say well OK, I'm to answer your question, I probably say that perhaps somebody's who's known the patient for longest uh that that that's the best place to start the discussion. But not often that person is that the person who's got the skills or the knowledge to do to do that. So sometimes you can have your own GP was with that patient for 60 years, but they might actually not be interested in the prescribing or not being there up to date with that. So it's a bit of a tricky question I think.

INT:  
OK. And when or when would it not be appropriate to involve patients?

HP01  
 if that's a valid and the conversation will make them upset.

HP01  
There's something that you believe that you should not be involved in the patient, and you should speak with the next of kin. So if by having a conversation with them about that, you know they, uh, you know, if the family tells you that you don't, they are really upset if you talk about medication or so you're gonna make them distressed.

HP01  
Then I think you should not involve the patient or spouse.   
Say the patient is dying, so the end of life denying the, talk to you about that. You should not involve the patient again.

INT:  
OK.

HP01  
That should be a decision that is done with the family and keeping the patient in, you know, comfortable and less distress should be your focus. So that time.

INT:  
OK. Thank you. And terms of when and when it's not appropriate to involve informal caregivers.

HP01  
Umm yeah, I think it's. I mean, it's the informal caregivers that they spend a lot of time with patients. So I think you should always have just seek their views on how their patient is doing and so on. But and the issue now? Umm, they should not have a say in what you're doing.

HP01  
I think that important to listen to. Yeah, but you surely you can value their opinion, but they should not have a say on what your decision is.

INT:  
OK would you like to say a little bit more about that?

HP01  
No, no, I think I think that's OK.

INT:  
OK. And what would assist engagement with health and social care colleagues to support shared decision making?

HP01  
Can you repeat that?

INT:  
Yes, sure.

INT:  
What would assist engagement with health and social care colleagues to support shared decision making?

HP01  
Thanks. Yeah, I think like MDT meetings with different organization can be helpful. Well, I'm so you can have you know other professionals involved, that patient is being seen by a physiotherapist or a occupational therapist. Or so the social services and so on are the ? all I think all the agencies involved in the patients care. They should be involved to just give the they're saying on the how the patient is doing and to understand a bit more about the picture of things and the I think that's the EMT approach is one of these. The approach works best when you're trying to do a complex decision for a complex patient. Really.

INT:  
OK.

HP01  
Thanks. Yeah.

INT:  
So the multidisciplinary team.

INT:  
And what would assist engagement or involvement of patients living with dementia or mild cognitive impairment and or their informal caregivers in the deprescribing process?

HP01  
OK. Again, I think make making sure they are involved in your decision making sure that you're, uh, you say you have a meeting with them. Like where they're like face to face or over the phone and making sure that you know you're transparent with them. You give them all the information they need about what you're trying to do and you share the same information that you have with them.

INT:  
OK.

HP01  
For them to understand more what you're trying to do for that patient and perhaps even sometime, well, I'm not sure if any like online resources that also what might be helpful. So, like signposting.

INT:  
And what would facilitate good communication with patients living with dementia? Mild cognitive impairment and border informal caregivers and deprescribing process.

HP01  
I'll be clear. Communication. So not rushing things.  
Especially with patient.

INT:  
Umm.

HP01  
Online resources I think can be quite difficult to understand for those patients, so that they always they won't be able to use any of that. So I think what whatever sort of like leaflets or explanation that can be like easily absorbed and simulated or related to them. And again it goes the same like again a meeting. I an appointment which is a clearly still like that structured so that person can easily understand, or you can clearly relate or you're trying to do rather than trying to, you know.

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

HP01  
I think it's a very it's a bit of a grey area. Umm, because the patient sometimes do like capacity, but it's sometimes it's difficult to assess whether it's capacity.

HP01  
And quite often it's easy just to say that. Let's not bother talking to them. I think there should be.

I'll be more of a try. Certainly to engage with them. If they have the capacity, but again, it's based on the initial assessment, will do they have capacity or no? And to do that, it just it just requires time and proper. Have thorough a bit of an assessment or knowing that patient a bit fairly well to do that you can just do that like in 30 seconds.

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

HP01  
I think I got a lighter approach. So, you know, involving other people around them know them best. All the other agency involved them, and so to get a feeling of how what the patient is without, you know, sometimes making your own, we have you can get your subjective view sometimes, but if you get a different point of view and just join together, sometimes you get like a bit of clearer point of view making shops here, the families involved as well really.

INT:  
OK. And you and on the other hand, in terms of any barriers today, involvement in shared decision making, you mentioned time there.

INT:  
Are there any other barriers?

HP01  
Yeah, I think time, prejudice or yeah.

INT:  
 I'm sorry you could just explain what you mean by prejudice.

HP01  
Yeah, dementia, cognitive impairment, then people, they assume their patient that person is not able to I think or speak for themselves. So I would say more like labelling. So you label officially that that noses and the person that needs can be often have assume that they're not able to decide for them.

INT:  
OK.

HP01  
Whilst you got some patient with the mild cognitive impairment or mild dementia, they absolutely and they can make a lot of decision for themselves.

INT:  
OK. Thank you. So that like labelling there and how do you feel about engaging informal caregivers of patients with dementia or mild cognitive impairment and shared decision making as part of the deprescribing process?

HP01  
Yeah. I think as I said before, it's important to hear from them because I don't want to spend most of the time with the patient, but again, then they're not the patient or the next of kin, so that you should not be umm, forced or like umm, they're not the one who there be deciding what you're doing. You can. I think it's useful to listen to what I have to say, but if they have an opinion about it, I think that that's their opinion.

INT:  
Mm-hmm.

HP01  
That shouldn't be what makes you decide what you're doing for the patient. I think you can take the facts from them and I'm trying to feel the to their opinion, because otherwise in the week can be.  
Of you almost like you can be influenced by them by. You have to bear in mind and not umm. You know the decision makers and know family or the next kin. So umm yeah.

INT:  
OK. Thank you. And again, anything that would help or on the other hand, not help in terms of their involvement in shared decision making.

HP01  
I don't think so. Kind of like what you talked about this before.

INT:  
OK, And what tools or resources are needed to facilitate shared decision making in relation to deprescribing for people living with dementia or mild cognitive impairment?

HP01  
OK, I think some evidence base so like perhaps like a risk calculator, there are some like, umm, talking about itself on your risk calculator. Those things are helpful and I'm gonna structure approach. So perhaps like a questionnaire or checklist or a some sort of tool that like I can empower the clinician and the whole like team making decision to clearly and simplistically also see what you know what can be something should be stopped or should not be stopped.

INT:  
Umm.

HP01  
Why should I be done something but can like?

HP01  
As I said, there are two question Something similar just stood like actually like a also record on the note to say we made this decision because this there is call shows that. So we thought to stop this, this medication.

INT:  
OK. Thank you.

HP01  
We discussed and risks and so on, and then we decide to do that if it makes sense, yeah.

INT:  
Yeah. Thank you. And anything that could be done in terms of supporting to best support patients living with dementia or mild cognitive impairment and then formal caregivers during the deprescribing process.

HP01  
Yeah, I think education about deprescribing because I think that there's some education going into healthcare and professionals. But again, I don't know how much of these education is also going into the patient themselves with the carers to say so. Look, if your mom is taking tablet for 40 years, speak to your doctors about stopping it, or if your mom's got dementia. You should talk. Speak. Think about stopping harmful drugs and so on. As far as I know I'm, I mean, uh, I don't know about any of those things. There might be something out there, but I think they'll be helpful if there isn't.

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

HP01  
I think they should have like I got systematic review, so a set of review time frame to say every so often they should be follow that up. I think ideally you're talking about our face to face review because with those people will be quite, yeah.

INT:  
Umm.

HP01  
I think will be quite difficult to review something that not seeing that person and. By just talking about the phone with somebody you can't really get the feel of the scene.

INT:  
Umm.

HP01  
The personas, the whole, whole thing, especially when you're making a fairly big decision stopping drug that can have catastrophic effect sometimes.

INT:  
Thank you. And who should be involved in the following up patients?

HP01  
Same as we said before. So again, because you, GP pharmacy still advanced partitions that they got some trainings or some interest in the deprescribing.

INT:  
OK. And in terms of how often patients medication should be reviewed.

HP01  
Uh, I'll say. Depends. I think she probably be at least once a year and then you need to have a proper full on review. But I guess after that if you have a proper structure medical review that then you could have a every two years or so or if you're introducing a new medication on the on the law and then you could have reduce the interval for pro save, somebody has over 5 or 6 medications added to the regular drugs and they could should be done to like be more frequently.

INT:  
OK. Thank you. And what are the potential facilitate to integrate shared decision making in relation to deprescribing medication for patients with dementia or mild cognitive impairment into your everyday practice?

HP01  
Uh. Say that again.

HP01  
So I missed the first bit.

INT:  
Sorry.

INT:  
Well, sorry.

What are the potential facilitators or the kind of enabling things to integrating shared decision making in relation to deprescribing medication for patients with dementia or mild cognitive impairment into your everyday practice?

HP01  
Ohh my practice. We do have a very good like pharmacy teams and they do tend to trigger those medical review. I personally find that that I always have a good care patient medication when you're having a, are you with them? I always think on the on the as in the background, there's always think that's something we could stop or think. Then you're the symptoms you presenting with calls by polypharmacy. We actually called giving you this, probably giving too many tablets, so I think is your. Somewhat is making sure your in your practice, whenever you're of looking at elderly and fail demented. Ohh, cognitive impairment impaired patients.

INT:  
Umm.

HP01  
You always look over their ? as it just sort of like a routine, and then every now and then you're you will see that they you your eye will follow on something you think actually this this this shouldn't be and here or why is that here and then you think she will stop it and then to triggers you too to think well let's think about the prescribing and then you follow that it's a bit more something you need to have embedded in you and I think the more the more and more people talk about deprescribing the more and more people will love start doing it sort of.

INT:  
OK. Thank you. And on the other hand, are there.

INT:  
What are the potential barriers to integrating shared decision making and relation to deprescribing medication for those patients into your everyday practice?

HP01  
Yeah, I think it's time constraints.

HP01  
If you're rushing, you have like 5 minutes to talk somebody out with a different problem.

You would not have time to deal with that, but again the that's where like other the wider team comes in. So you can always you can think of that needs the. Then you can always we have a system allowed tasking each other or letting flagging this up to somebody had to say please can you review that?

INT:  
OK. Thank you. And are there 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?

HP01  
Umm yeah, I think we do actually have a I mean we having in a couple of weeks like one hour pharmacies doing a, umm, a training about deprescribing.

INT:  
Umm.

HP01  
So I think we kind of handle that and but yes, I think every still practices or every place service should have like I think here at least what the like trainings about you or even like something like mandatory for all or prescribed as the shooter heavier you have a refresher about you know what drugs should be stopped, what was deprescribing what? Why is it important to think about that? Yes.

INT:  
Thank you.

And then the other training or educational needs.

HP01  
Not that I can think of.

INT:  
OK.

INT:  
And finally, it's there anything else you want to tell me or anything you wish to add?

INT:  
What you have already said in the interview.

HP01  
No, I don't think so.

INT:  
Just to let you know, we've come to the end of the interview.