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

**Transcript**

**HP06**

INT:  
So thank thanks very much for agreeing to take part in today's interview on Monday, the 31st of July at 9:30. So I just like to start with quite an open question. Can you tell me about the care you provide to people with dementia or mild cognitive impairment, please?

HP06:  
Umm so as a GP I am. I'm involved in both. Umm. Screening for dementia or cognitive impairment and uh referring patient organising investigations and uh referring patients where there are concerns about cognitive impairment, tool or dementia. And then, yeah, then I I'm involved in obviously in in seeing patients, you're being diagnosed with dementia and either to do with dementia and their mental health. So we, we do routine dementia reviews and dementia care plan reviews as part of our GP contracts and we are often at some point will take over prescribing of dementia medications from memory assessment services. Ah, you sometimes might get involved in uh we referring patients or sorting out and prescribing for psychotropic medications, for various psychological problems associated with dementia or sometimes involved in dealing with physical symptoms that are associated with dementia. I also have some personal issues with dementia in terms of I don't if that's relevant. Sorry, is that relevant?

INT:  
Yeah.

HP06:  
So yeah, so my (relative) has been diagnosed with early onset dementia. From at the age of about 63 is not much older than me. Uh, so I'm involved a bit with that side of things on a family level as well.

INT:  
thank you very much. And mow much of your everyday kind of workload -  
I know you were so mentioned personally as well, but in terms of your, your kind of work as a GP are, are you involved in the care of people with dementia or mild cognitive impairment?

HP06:   
Umm would say it's a. It's a fairly a common umm issue in in in my day-to-day work so I think around half of our patient list is over the age of 65. So probably relative to some other practices it with different demographics we probably got a higher prevalence rate of dementia and cognitive impairment in our patient list it's and I don't, I'm not the usual GP to any patients in care homes in our patch. So I don't get as much exposure as those GPs probably and but certainly it's not uncommon for me to see a patient who's worried about their memory or their relative or next of kin or someone is worried about their memory. And or to and do, or occasionally an MSE, umm or something, or GP code or some sort of cognitive assessment.

INT:  
Umm.

HP06:  
UM order investigations like bloods and so on for cognitive impairment or queries along that line and not uncommon to get involved in. Indeed, in doing referrals to memory assessment services. UM, that's pretty common in terms of, then follow up and longer term management. That's probably less of a of a thing that I'm aware that I'm involved with, but I guess I am a lot along the way, but I'm unless I can't sort of recall it so much to mind. I think it's more my end seem feels like it's case finding and referring for diagnosis or not, uh, as the case may be.

INT:  
And what involvement do you have in medication management for those patients?

HP06:  
So and variable, so some pay most patients in our area at least initially. The prescriptions are through the memory assessment service or the mental health side, rather than directly from us. And but in most cases, at some point and it varies somewhat, they will ask us to take over prescribing. So until we take a prescribing, the involvement is minimal apart from if they come to us with suspected side effects or something, we have to raise that with the relevant team who are prescribing it. And ohh uh, we might organize the monitoring any blood test that required say or ECG or something like that of those medications on behalf of the prescribing service. Sometimes we do that, uh, and then yes, sometimes we do take over the prescribing as well. So then it forms part of their general medication review as well.

INT:  
OK.

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

HP06:  
I mean, it's something that that I do think about and particularly in in more advanced dementia. I'm quite keen to do it where possible and where sort of appropriate and in the interest of the patient or with the consent of the patient, if they still have consent to their capacity, rather to give consent, or if there's a an active power of attorney or something like that, that that they're involved in that as well obviously. But all other things being equal, yeah, I would tend to try to do that and certainly for things I often see patients who are still on the statins, they fairly advanced stage of dementia and question whether that's still in their best interest to carry on with and general uh, things like diabetes, diabetes medications and might deprescribe or accept a lower level. sorry, a higher threat threshold of diabetes control perhaps. And, but bearing in mind that those things obviously have a are all risk factors for the dementia as well in the 1st place. So I can get a bit confused. I think sometimes about which way I should be pushing or pulling and blood pressure medications. Again, it's something that I'd commonly be looking at deprescribing and. But yeah, I mean it certainly in terms of mild cognitive impairment and earlier stages of dementia than I I'm not so much focused on deprescribing in those patients unless it's indicated for other reasons

INT:  
And any overall advantages that you can identify with deprescribing of inappropriate medication for those patients?

HP06:  
Yeah. So if the if the medication is inappropriate then uh, then there's obviously no or the bent that the harms are outweighed by the benefits. So reduced side effects I would have thought reduced risk of falls often and the security from that in terms of fracture risks and hospital admissions and so on. And it can. Simplifying a medical medication regimen can be helpful for anyone, but particularly for patients with dementia, and can be helpful. And other things I've seen. Uh, yeah, those would be the main ones.

INT:  
Umm.

HP06  
Avoiding side effects and adverse events that sort of associated with risks associated with medications and simplification of medication measurements.

INT:  
Umm, thank you and on the other hand, any disadvantages?

HP06  
I I'm. I yeah, I think I saw related to in my earlier answer about and how particularly in cases of mixed dementia or vascular dementia, where marked, vascular risk factors are part and parcel. Then I do feel sometimes like you on the one hand, I'm looking to do. I might be looking to deprescribe uh, but on the other hand, I'm conscious that in so doing, I might be increasing the risk of progression or deterioration of that type of dementia. So that's the main one. It's also sometimes just making changes, sometimes to medications in itself can be confusing. So if they've got a blister pack set up and you know they and all they and all their carer are used to a certain set of medications, it can be a bit of an upheaval and it and it can lead to errors and things. If you start tinkering or changing doses and medications that are involved, so sometimes we sort of let sleeping dogs lie sort of thing, and that in itself can cause confusion and medication errors and things, I think.

INT:  
Thank you. And anything you think that could help resolve some of the challenges that any thoughts you've had?

HP06  
And. I think uh, in terms of making a deprescribing decisions, tools to help you, like along with the sort of stop start type thing can be quite helpful in terms of just giving you know if you're doing a medication review to give you ideas for things to consider and or discuss uh as options for, for safe and appropriate deprescribing and can be quite helpful. So you know, if there's some something that that, that will generate a a list of ideas, that of what medications you might want to look at, then that could be quite helpful. And very often, these patients are gonna be on lots of different medications, so sometimes it can feel like quite a task to start changing things because there's so many of them to choose from. Which one do you go for? 1st and so on, both for you and for the patient and carer.

INT:  
Umm.

HP06  
So yeah, I think I think a tool that helps sort of prioritize and make in sort of support decision making is helpful and also good access to good clear advice and in written electronic. Iforms? and is quite helpful to support medication changes if that information is aimed at patients and carers. And whether that's a website or whether that's, you know, patient information leaflets, either electronic or written form, I think anything like that with around medication is always helpful, uh, and it to support people in understanding what's happening and why. And or even if it's just a patient decision aid sort of thing or a carer decision aid for patients who lack capacity themselves to, to give them options, to choose from and the sort of the pros and the cons of each option. Umm. So they can make an informed choice about what they want to do with their medications.

INT:  
Thank you. And thinking no, we touched on some of the medications, but what types of medications would you feel most comfortable deprescribing for people living with dementia or mild cognitive impairment and why?

HP06  
And I think that, uh, again, sort of certainly at the at the more advanced end, I'd feel more comfortable deprescribing medications that are preventative medications. Uh for things that that may not be really that that they're unlikely to affect them in their years of life left. So, for example, statins is a good example there?

I would be quite comfortable describing satin someone with advanced dementia if I felt they had less than 10 years of quality life left on the on the basis of statins being justified on a sort of 10 year risk basis.

INT:  
And umm.

HP06  
Umm, I would be. What else would I be? Uh. Happy with I would accept slightly higher blood pressure thresholds and slightly higher diabetes thresholds for patients, so unless they're blood pressure and diabetes control was particularly poor, I'd usually be relatively comfortable in, in, in reducing those at types of medications for them as well. And I would tend not to be so comfortable for things like, umm, things that are either symptomatic treatment. So PPI's or something like that and or um or things like bone protection and things I'd I would tend to try and keep on board if they were.

INT:  
Umm.

HP06  
Relevant from an osteoporosis or fracture risk point of view to try again to try and minimize risk of fractures and hospital admissions. Really.

INT:  
Exchange and then and then the others on. On the other hand, that you would be reluctant to deprescribe.

HP06  
I think the main ones would be anything that's treating symptoms that they currently have, be that sickness or pain or and. Reflex or other symptoms that might impair their quality of life and or things where deep scribing increases their risk of potentially of admissions and things and things like that.

INT:  
Thank you. And is there anything that would help support you in making you feel comfortable to deprescribe medication?

HP06  
Umm yeah, I think I really like things like the website gpevidence.org or those sorts of things where. Uh, what?

INT:  
Umm.

HP06  
Which give you sort of those sort of risk charts with the hundred faces on no treatment versus treatment and so on and gives you the all the absolute risk reductions and the relative risk reductions and so on that you can use yourself to understand the risks and benefits, but also share with patients or carers as well. So would like things like that if something like that's available. And yeah, I really like patient decision aids as well where appropriate. So if there's something that can support patients and carers to make their own informed, which is, if I feel the patients making an informed choice, then I'm much more comfortable with whatever has been chosen than if I'm doing it off my own bat. If that if that makes sense.

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?

HP06  
The main what?

INT:  
It's nine things.

HP06  
Sorry, the main things.

INT:  
Just things that that you think should be in place to enable successful deprescribing.

HP06  
Yeah, I think I think basically as much, um, user-friendly access to as much to as reliable evidence base as possible for both professionals and for patients and carers as they there's evidence based that that sets out risks and harms and that and that that supports shared decision making between professionals and patients and carers.

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

HP06  
Yeah, I mean quite variable really. I as a as a general rule, I think I would say that that patients themselves with mild cognitive impairment or dementia are usually. Fairly open and keen on deprescribing as a mentioned they often be on lots of medications anyway, which they don't generally like, and they're keen to reduce medications if possible. So I feel like that's often an open door where it might become more tricky is when you're dealing with patients next of kin and or some informal carer where they can see it is that you're withdrawing care or your you know that you're giving them a you you've given up on that patient or they're not. They're getting a sort of second class service because you or you're trying to cut costs or these sorts of negativity thing, summations can come into play and you might have to do some work around disguising them as those of those notions and making sure that they are confident that that, that it's the patients best interest that you have at heart here.

INT:  
Umm.

HP06  
Not for any other reasons, and I think I think that can be a barrier to overcome sometimes.

INT:  
But that is family member.

HP06  
Yeah, absolutely.

INT:  
The next perception of yeah, OK, yeah, yeah.

HP06  
Yeah, the very often they will be more keen, you know that you throw everything at someone and to minimize risk as they see it and then then the patient who actually takes the medications. It's.

INT:  
Thank you. And just from your observations, what works well about those experiences of having deprescribing discussions with people you know.

HP06  
Yeah, I think I think what works well is where there's a good relationship between the doctor and the patient and their career and the and the everyone. And everyone's open with everyone else, so it. So it's not a case where the where the informal carer or the relative is telling you stuff about the patient that they want to happen, but they don't want the patient to know that they've told you and that one gets tricky. But what works well is when everyone's open, everyone's on the same page.

Umm. Everyone knows that everyone knows, as it were, and everyone's involved, feels involved in in the in the discussion and the decision making and feels that they know what to do if it's going wrong. Or that there's a clear follow up plan in place or something like that. They feel supported and not just abandoned. I think that's when it works well.

INT:  
OK.

INT:  
And on the other hand, but what challenges have you encountered?

HP06  
Yeah.

HP06  
So, uh, so one challenge is where and is where people want to who are concerned about the patient want to give you share their concerns with you and or even get you to do things or refer or change treatments or whatever.

Without the patient's knowledge or where patients where carers, sorry or next to kins, want you to even to make an appoint with a patient to go through these things, even if about not tell the patient why you're doing it or well the what, you know, who's asked them to do it or anything like that. And so that that I find that a real challenge or when there's family conflicts are different family members take a different view on these things. They might be some families, family members. Who are you? Are very less affair and others who are very proactive in terms of what they want for their for the patient, so that that that can be challenging as well. And ohh where the patient is unsupported relatively and in in terms of their medications. And as it's sort of trying to manage them on their own, but you've got caused to think that they're not really coping with managing it on their own. And even with blister packs and things like that, often patients are running into trouble. And that can be a challenge to know how to help them best with that.

INT:  
Umm, thank you.

INT:  
And what would help facilitate conversations?

HP06  
Umm. I think. Uh, as always, I think if it's umm, if it's target and that's part of quota for it's part of one of the IF things or something like that. Excuse me.

INT:  
Let's see.

HP06  
Thank you.

HP06  
And then that can help to drive activity and if there is a target sort of associated with and I'm using a deprescribing tool or whatever it is that you could that you could easily wrap up into a into a, into a target and that could help I think.

HP06  
I having access to. Let's say good evidence base both two types, one aimed at professionals 1 aimed at parents that patients and carers.

INT:  
Umm.

HP06  
Uh could help as well.

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

HP06  
I think it varies practice to practice depending on uh, there. So what staff they have and what size they are and what they're sort of culture is? Uhm, so in some places it would be the sort of usual GP, the registered GP, particularly in those areas. Those practices, rather than operating more personal list system where you're more likely to have continuity of care with one GP overtime and so but that that's not the case email practices. So I think you know the practices, possibly a pharmacist or someone like that might be better placed. So yeah, I think it varies quite a lot practice to practice.

INT:  
Variable and.

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

HP06  
Umm, not that I can think of. No, that would that might be involved, no?

INT:  
I think you and maybe a similar answer, but just checking it who is best placed to lead the discussion.

HP06  
Umm.

INT:  
Deprescribing discussions in primary care.

HP06  
Uh, yeah. As a professional, yeah, it probably is. I probably used the same answer that it would depend on the practice set up and as to as to who might be best placed, and I think ideally we probably you know, ideally it probably is umm, uh prescribing professional be their doctor or GP or whoever. But who is who has a an established relationship with that patient and informal carer that is their registered doctor or usual doctor or something? Umm but yeah, there will be practices where that's not really the case. There isn't such a GP, in which case it if it's more so protocol based or application of a of a scoring system or requires longer than 10 minutes, then it might be better for a for a … or something if practice have access to that sort of service or that sort of staff member.

INT:  
Thank you.   
Now there any occasions when it is or is not appropriate to involve patients that you can think of?

HP06  
Uh, I can't readily think of a over of an occasion where it's not appropriate to involve patients other than if they lack capacity to the extent that that it would, that it would just be, uh, meaningless and maybe provoke anxiety or something. But that would be very that would be very much towards the end stages.

INT:  
Umm.

HP06  
So you would have thought, I think, even if they lack capacity to consent and instead in appropriate to involve them as much as possible or as much as they wish to be involved, and even if they're not making the final decision that they that they have the opportunity to be aware of. And involved in discussions, I think it's a good principle to try and hold to as much as you can and. Uh. I don't really think of anything else new.

INT:  
  
INT:  
And the same question for informal caregivers.

HP06  
Umm, I think well there it's I think it's basically comes down to what you what you judge to be the capacity of the and of the patient and what their wishes are. So if. If the patient doesn't want the informal carer to be involved in that discussion. And you even think they might have capacity to make that decision, then I would tend not to involve them.

INT:  
Umm.

HP06  
I might encourage them to involve the informal carer or something like that, but it in the final analysis and unless I was clear that they lacked capacity to make decisions themselves about that sort of thing, then I would be, I would respect their wishes basically come down to what they wanted to do, even if I might recommend that they share it.

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

HP06:  
  
I think basically, uh, good communication and so ideally sharing one record system would be would be the best. I don't see any realistic prospects of that happening anytime soon, so otherwise it's good communication. Open channels of communication and easy communication. So having and a facilitator making it as easy as possible to be able to, for example, to email? Uh pharmacy or, uh? A medical team or whoever else might be involved in this particular patient and. Uh, yeah, having an email address that that we can use for, for queries or for sharing information or what have you would be really helpful because very often you're trying to do these things outside of normal working hours. By the nature of the of the way things work, you might not have time to do it during working hours. So you'll be doing it in the evenings or weekends or whatever. So very often phone lines are not very helpful. I find for things like this, whereas emails are much more helpful. And yeah, that would that says yes, it's back. Either record sharing or really good open channels of communication that work and that are, you know, regularly scene and so on.

INT:  
Key and what would assist engagement or involvement of patients with dementia?

INT:

and mild cognitive impairment and all their informal caregivers in the deprescribing process.

HP06  
Probably the same thing and feeling that they have that they, you know, they know who to call or who to email or who to, how you know how to how to access help and information if and when they need it. And equally that they have a clear plan that they that they know what the plan is either in terms of deprescribing it, it's like a weaning thing or something like that perhaps or in terms of follow up on the effects of the uh of the deprescribing and how you're monitoring that and so on. So yeah, and clear a clear sense of ohh how to access help if they're running into trouble. Of what the follow up arrangements are and um, yes, I got a can't remember.

HP06  
Also, it's gonna say sorry.

INT:  
No, but that's fine. And in terms of that facilitating that good communication, what?

INT:  
What language should be used in communicating information about medications with people with dementia or mild cognitive impairment and then informal caregivers.

HP06  
Well, I think a simple and clear as possible. Umm. Yeah, so, so avoiding jargon aware of a possible explaining jargon if, if not possible to avoid it is.

HP06  
Yeah, it is simple basic plain English as assuming they speak English as possible or having yeah translation services then or. And you know, information in in different languages as well.

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

HP06  
Uh, I feel it's important and it's something I strive to do. Uh, as a matter of routine. And but I feel that it's probably I'm not. I'm not immediately aware of resources to help with it as I am in in other areas.

INT:  
Would help facilitate their involvement in shared decision making.

HP06  
Uh, so yeah.

HP06  
So, umm, good, patient decision aids. Um- Websites with umm evidence based information but aimed at patients and their carers. In in planning plain language and that can be translated and good evidence is or user-friendly accessible format for us as health professionals as well to sort of help us both prioritize. And maybe explore with patients which side effects they want to avoid or you know which and which thing, which medication, which medical conditions rather that they want. They particularly want to avoid or that sort of thing, so that so that we can come up with a sort of a plan of priority and also get a sense of how much difference it might make to deprescribe something.

INT:  
Thank you.

INT:  
And on the other hand, what are the barriers to engaging patients with dementia?

INT:  
Mild cognitive impairment and shared decision making.

HP06  
So barriers can be to do with umm, capacity of the patient's, uhm, different agendas. But if it, particularly with patients who lack capacity, different agendas of other interested parties and the patient and you and. I think yeah. Feelings of and it's an external pressures, then of feelings of being a burden. Um or giving up on Ohh on life all being given up on by the health service. I think of being abandoned people feel that's a lot. And it getting patients with cognitive impairment or dementia to remember to come to appointments and we can do barrier and as part of the, the disease and. Else, sometimes lack of access to or ability to use a other means of communication like telephones or email or texts and can be a barrier. Yeah, those are the main ones that I encounter.

INT:  
Thank you.

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

HP06  
Yeah, I mean, so that depends on the patient themselves really. So um I feel I feel comfortable if the patient has either has capacity to say to, to make decisions themselves and is happy and I don't feel they've been coerced or anything. It's happy to share that information with their carer. Then I'm happy. Or if I'm clear that the patient lacks capacity and it's in their in the patient's best interest that I share that information with the informal carer, then I'm happy. It is tricky. Sometimes I want my want to involve the carer and but if I feel that the patient. Doesn't want that, and I feel they have capacity. So to refuse then I would defer to the to the patients autonomy on that.

INT:  
OK, And then anything there that would help facilitate the informal caregivers involvement and shared decision making?

HP06:  
  
I mean probably having some, uh, as well as the other things that we mentioned for patients themselves. So they might be helpful for informal carers as well in terms of patient decision making or a website that supports decision making and so on deprescribing. But also maybe something that touches upon issues of. That's the consent. And so on and explains what with what we can and cannot do. With without patients consent where they where they lap, where they don't lack capacity.

HP06:  
Sorry, where they have capacity and the limitations on what we can and can't do without the patients capacity because that's the common theme to have in those discussions.

INT:  
And then he barriers to them involvement and shared decision making.

INT: This is for informal caregivers.

HP06  
But sometimes the patient themselves can be a barrier if they don't want them to be involved. Uh umm. Uh, it's can't think of anything else obvious. To me.

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?

HP06:

Yeah, I think tools of would useful tools would be. Decision aids, UM and or you know websites or something like that where you can, where you can access information to help you make decisions for yourself about medications and what you have. You know, if you could feed in what medications you're on and it could ask you as a sort of algorithm that it then sort of sets out for you what the risks and benefits of that medication is, what the medication is for and what sort of or to get them to this out, think about what's what things they want to avoid either side effect or medical outcomes and what things they're not. So bothered about might help and to prioritize. What they want to do in terms of deprescribing as well. So yeah, good evidence based stuff that's accessible to patients and their carers and to sort of and directed and written in such a way as to, to, to be readily understood and so on by then and similarly so they're evidence based package. Uh umm, be that a tool or a just a general website where, umm, or something like that where you might be able to again feed in what medication is the patients on and find out what the risks and benefits of stopping that medication or what the evidence is for stopping that medication and any recommendations for monitoring or so on any sort of guidelines really that that give you a structure of how to go about it.

INT:  
Thank you.

INT:  
And any thoughts around umm patients or their informal caregivers can be supported?

HP06  
  
I think I think follow up is part of it.So sit and that they know they're being followed up and they know what the follow up plan is so.  
And so that they know if and when there's a review scheduled to take place of the effect of that deprescribing. And they know in the meantime, what to watch out for when seek help sooner or and or if they've got concerns themselves. What? How they act on those?   
You know who they who they go to, how they contact them and so on and that they have confidence that there is, uh, that that that, that, that there is a way of highlighting those concerns if they arise.

INT:  
Thank you.

INT:  
And who should be following up patients?

HP06  
Well, ideally the, whoever it is who's initiated the changes, I would say so, yeah. So it kind of depends on who's, who's initiated the deprescribing, or whose … the prescribing and changed it.

INT:  
Thank you.

HP06  
So for like continuity of care released to understand what conversations have already been had around it and why decision has been made and what the what, the thinking was what the plan was, I think yeah best if it's if it's the same person, he reviews their own actions.

INT:  
And OK. And how often should patients medication be reviewed?

HP06  
Uh, it's is a very variable one I think about depending on what medications they're on and what their health status is, what conditions they have, and it will vary quite widely and. Anything between six weeks to 12 months I think would be would take in most of the medication reviews that I set up anyway, occasionally more, more frequent than that if it's applicable to whatever medications are involved, maybe even weekly or something. But yeah, it really it really varies.

INT:  
OK. And what are the potential facilitators to integrating shared decision making in relation to deeper scribing medication for patients with dementia or mild cognitive impairment into your everyday practice?

INT:  
So what are the enablers or facilitators to integrating that?

HP06  
Needless of it and. Well, we do have some things embedded in our software to you to help with like medication reviews that will include things like a stop start criteria review that you can you can access or click on to use as part of that review. And so that that would be an enabled error facilitator and. Think of anything else on top of my head.

INT:  
Yeah, sure. And on the other hand, what are the potential barriers to integrating shared decision making and relation to deprescribing patients into your everyday practice?

HP06  
I think the number one would be lack of appointments. Umm, just generally, so it's really difficult to set up things that. There's so many more, so much more demand for appointments than there are appointments to go around. So yeah, lack of appointments and lack of staff often, and it's to deliver those appointments.  
And this does she have workload in volume of stuff that we have to deal with already? Uh, it just means it's just one more thing to find space for, which you may not be able to find space for. And then on in an in an actual appointment, the time to do so. So commonly it would be uncommon for such a patient to come just because of that sort of medication review or something like that. Likely that it would be part and parcel of a much wider view with multiple symptoms, multiple problems, multiple things that you might want to that you might prioritize over and above he prescribing. And so it might get. So yeah, so space and time to do it, it's probably the main barrier.

INT:  
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?

HP06  
Yeah, I think we and I think if there was a if there are or if there were tools that would help with it then having some training that we could access in how to use those tools would be helpful. Maybe some communication skills stuff around? And way easier to discussing it. Ways of bringing it up and so on. And yet, guidance on how to do it, so practical guidance and in terms of what to stop, how do we do stop? Do over what time period? When should you review what? What bloods or blood pressure or whatever do you should you be checking and all these sorts of things that the more they're a protocol to follow, the better I think.

NT:  
Thank you.

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

HP06  
No, I don't think so. Thank you. Sure.